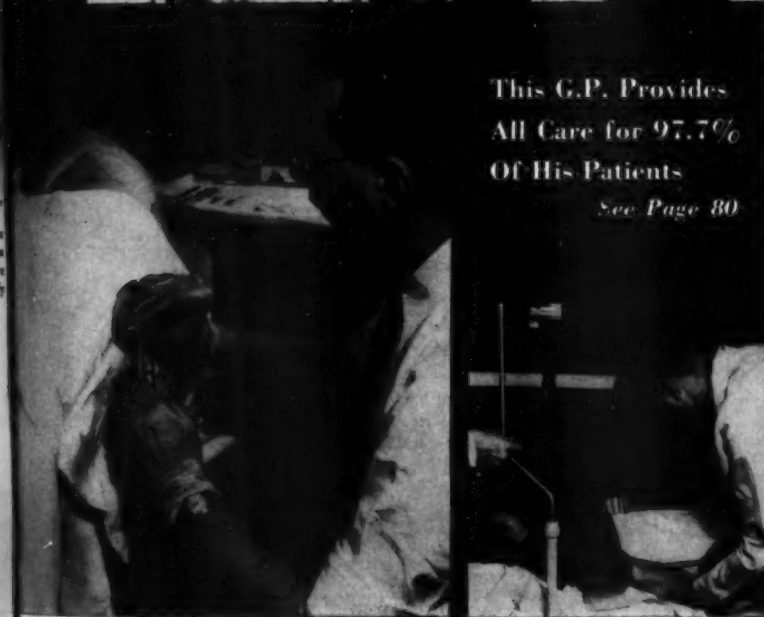


July Medical Economics



This G.P. Provides
All Care for 97.7%
Of His Patients

See Page 80



Not three...but **Four**

Four factors are now recognized in the treatment of peptic ulcer...

- ① **Neutralizing hyperacidity.** KOLANTYL includes a superior antacid combination (magnesium oxide and aluminum hydroxide, also a specific antipeptic) for two-way, balanced antacid activity.
- ② **Protecting the crater.** KOLANTYL includes a superior demulcent (methylcellulose, a synthetic mucin) which forms a protective coating over the ulcerated mucosa.
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Inactivation of lysozyme . . . with a proven antilysozyme, sodium lauryl sulfate. Laboratory research^{1,2,3} and clinical results⁴ indicate that the enzyme lysozyme is one of the etiologic agents of peptic ulcer. By inhibiting or inactivating lysozyme, KOLANTYL—and only KOLANTYL—provides the important 4th factor toward more complete control of peptic ulcer.



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1. Meyer, K. et al. *Am. J. Med.* 5:482, 1948. 2. Wang, K. J. and Grossman, M. I. *Am. J. Phys.* 155:476, 1948. 3. Green, W. J. *Am. J. Med. Sc.* 217:581, 1949. 4. Hafford, A. B. *Rev. of Gastroenterology*, 18:508, 1953.

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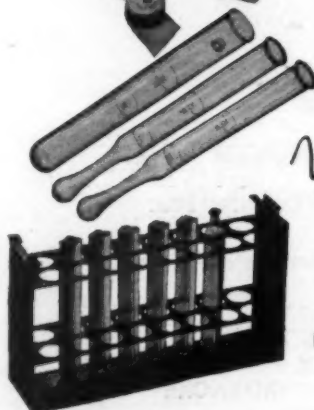


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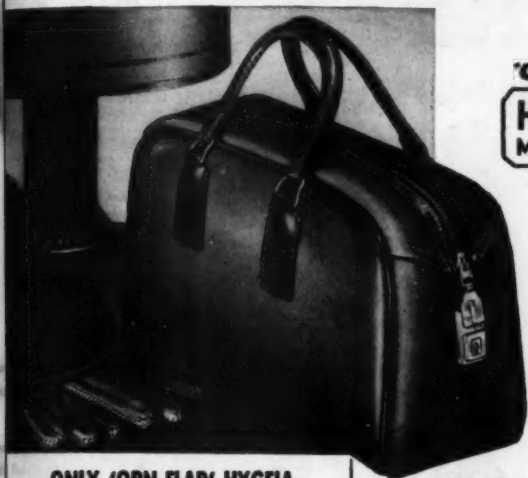
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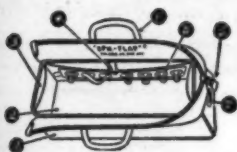


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In minor surgery for both adult and child, Pickrell³ lists numerous painful procedures often performed in the doctor's office where "Trilene" may be effectively employed. These include reduction of fractures, removal of painful dressings, incision and drainage of abscesses, and cystoscopies.

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1. Gordon, R. A., and Morton, M. V.: *Anesthesiology* 12:680 (Nov.) 1951.

2. Smith, G.: *GP* 5:61 (Apr.) 1952.

3. Pickrell, K. L.; Stephen, C. R.; Broadbent, T. R.; Masters, F. W., and Georgiade, N. G.: *In Press*.

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Lactic Acid.....	0.4
Minerals.....	0.6

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A normal dilution of Pelargon prepared with a quart of water supplies one-third more than the generally accepted requirements of infants for vitamins A, B₁, B₂, C, and D, and for iron.

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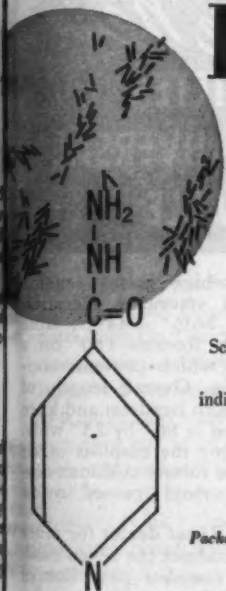
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Panorama

Federal food and drug agents have impounded three "cosmic-ray radiators" that 85-year-old Dr. W. Eason Williams of Denver, Col., allegedly used in his practice. To the charge that the little metal disks were rayless and non-cosmic, the doctor had a quick answer: His "radiators," he reportedly said, could cure practically anything from "high and low blood pressure to craziness" . . . The old order changeth—at least, apparently, in West Virginia. A majority of newspaper editors polled by the state medical society there say that physicians now take an active part in local civic and political affairs. One editor, in fact, insists they're *too* active.

Should hospitals employ practical nurses in the operating room? No reason why they shouldn't if the surgeon—who is legally responsible for the conduct of an operation—consents, says Dr. Charles U. Letourneau of the American Hospital Association . . . When Dr. Curtis S. Grove of Los Angeles refused to respond to a hypodermic needle jabbed repeatedly into him by two thugs who wanted to know where he kept his narcotics, the men gave up. As an alternative, they taped him to his examining table and made off with assorted drugs plus \$75 in cash . . . Beyond the call of duty: In its eulogy of a defunct physician, the Pomeroy (Ohio) Democrat notes that: "For 59 years he practiced medicine, being responsible for most of the babies born in this community."

While ferreting out undesirables on the city payroll, Chicago investigators turned up an 80-year-old physician with a police record. Fifty-two years ago, he admitted on a questionnaire, he'd been fined \$12 for riding his bicycle on the sidewalk . . . Are doctors writing fewer papers? Seems so, says

Editor Dwight L. Wilbur of California Medicine, who notes a dwindling supply of unsolicited medical manuscripts. "There is space waiting for good, well-written articles," he reports . . . After studying fifty-two items on "controversial subjects" in the Journal A.M.A., the left-leaning Committee for the Nation's Health caustically reports no evidence of dissension in the ranks. All but four of the items (three of them "brief" letters to the editor) reflected the opinions of A.M.A. leadership, it says.

Shortage of about 47,000 professional and technical hospital personnel (not including graduate nurses) is reported by the American Hospital Association. Most needed: about 30,000 practical nurses. Also wanted in large numbers: laboratory technicians and dieticians . . . Doctors who gravitate to cities are merely following the crowd: Recently released figures from the 1950 census show that one out of twenty big-city dwellers moved to the city in the preceding year alone . . . If blood donations were tax deductible as charitable gifts, more people might give more blood, says John H. Hayes, director of Lenox Hill Hospital, New York. He suggests a \$25 tax deduction for each pint donated.

How to deflate a patient, as the Chicago Daily News tells it: When a prominent (and very dignified) Chicagoan, who was suffering from a stomach disorder, turned up for his appointment with a specialist, the receptionist purred into the office phone, "Your 12 o'clock stomach is here, Doctor" . . . The Women's Auxiliary of the Colorado State Medical Society is campaigning for better manners among motorists, to help cut down traffic casualties. The doctors' wives have found just the spot for putting up safety posters: their husbands' offices . . . To deal with the shortage of nurses, Dr. Marcus D. Kogel, New York's Commissioner of Hospitals, offers this solution: Recruit women over 40 for a "belated career" in practical nursing.

Commenting on the death of a popular small-town physician, the Dallas (Tex.) News says: "It is said that a stadium twice the size of Soldier Field couldn't hold the



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Calamine and Benadryl® Hydrochloride Lotion

Antipruritic, soothing, and cooling. CALADRYL quickly relieves the distress of itching skin. The antihistaminic-antipruritic action of this smooth, creamy lotion provides comfort in sunburn, prickly heat, diaper rash, insect bites, poison ivy or poison oak dermatitis, urticaria, and minor skin irritations.

CALADRYL is pleasant to use, easy to apply, and cosmetically inconspicuous. It does not stain clothing, does not rub off, and is easily removed by rinsing.

CALADRYL, containing Benadryl Hydrochloride 1 per cent in a calamine-type lotion base, is supplied in 6-ounce bottles, wide-mouthed for easy application.



Parke, Davis & Company
DETROIT, MICHIGAN

people he befriended. The doctor who is understanding, sympathetic, and humane may not have the biggest bank account. But he's a bulwark against Marxian medicine" . . . Physician-curethymself department: When Dr. Herman N. Bundesen, president of the Chicago Board of Health, crossed a street in the middle of the block, two cars narrowly missed him and he broke his wrist warding off a third. His comment: "And for years I've been preaching against jay-walking" . . . The new power-steering feature of a well-known automobile is being promoted among local doctors by a Dennison, Ohio, dealer. His gambit: Prescribe this easy-steering car for patients who need to take it easy.

Medical schools too often select students only for their aptitude in the physical sciences, says Professor Samuel Hadden of the University of Pennsylvania School of Medicine. Many students of this type, he points out, are "as depersonalized as mashed potatoes"—hence, totally unsuited to the private practice of medicine . . . Watch the expiration date of your malpractice coverage if you're insured with the American Policyholders Insurance Company. The Massachusetts Medical Society warns that this company is giving up malpractice insurance and will not renew such policies . . . The British Medical Journal reports that a man who vowed he'd give his right arm to find a cure for his arthritic daughter eventually lost the arm in an automobile accident. Soon afterward, the girl's arthritis disappeared.

Post-graduate courses by telephone, initiated some time ago by Indiana doctors, have caught on in Texas as well. Members of fifty-eight local Texas medical societies (nearly half of those in the state) recently listened to their first hour-long panel discussion of this kind . . . Doctor-philanthropist: The Los Angeles Red Cross credits 81-year-old Dr. William T. McMillan with raising over \$100,000 for it in the twenty-five years since he first volunteered to help . . . Doctors' philanthropist: The Physicians' Home, New York, has been willed more than \$700,000 to "establish and maintain" a home "with a comfortable garden" for aged physicians. The donor: Teofilo Parodi, retired New York physician, who died two years ago at age 87.

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Bottles of 100 and 1000.

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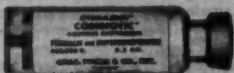


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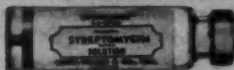
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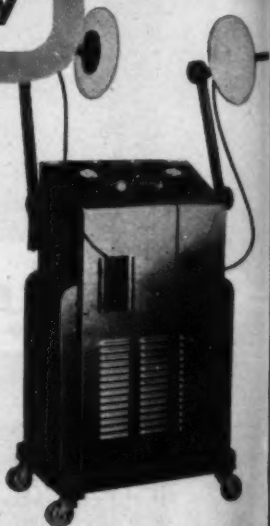


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The high-frequency, push-pull oscillator circuit with two Triode power tubes, assures an ample power reserve—always under the smooth, precise visual and electronic control of the operator. A

convenient patient "shut-off" cord, Preset Dosage Timer, and positive Resonance Control are additional significant features.

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Available: Bottles of 100 tablets. Each tablet contains mercuride 60 mg. and ascorbic acid 100 mg.

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Genuine Bayer Aspirin*

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AS AN ANTIHISTAMINE:

Phenergan compared dose for dose with other available antihistaminic drugs proved to be the most efficacious and the longest-acting drug.¹

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Phenergan applied topically has been shown to be significantly more potent than other antihistamines,^{2,3} cocaine,⁴ or procaine.²

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Hydrochloride
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Applications are practically invisible because the cream quickly disappears when gently rubbed on the skin.

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Squeeze tubes of 1.12 oz.

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When drying, astringent action is desired.

Blends with skin tones.

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Bottles of 4 fl. oz.

1. Peshkin, M.M. et al.: *Ann. Allergy* 9:727, 1951.
2. Landau, S.M. et al.: *J. Allergy* 22:19, 1951.
3. Code, C.F. et al.: *Bull. New-York Acad. Sc.* 50:1177, 1950.
4. Halpern, B.N. et al.: *Compt. rend. Soc. biol.* 141:1125, 1947.

Wyeth

Wyeth Incorporated, Philadelphia 2, Pa.



in irritable colon

Mucilose

HIGHLY PURIFIED HEMICELLULOSE OF PSYLLIUM

FIVE
DOSAGE
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1. **Mucilose Granules Special Formula** (with dextrose), tins of 4 oz. and 1 lb. Pleasant tasting, crunchy granules.
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5. **Mucilose with Cascara Granules**, tins of 4 oz. Contain 1 grain of powdered cascara per heaping teaspoonful (5 Gm.). Particularly valuable during transitional treatment of confirmed cases of chronic constipation.

XUM

...the important problem of constipation"
 the management of the irritable colon
 could not be overlooked.
 It is imperative that the patient stop taking laxatives."
 The routine use of a hydrophilic colloid
 such as...Mucilose...is often gratifying, and
 never contraindicated in irritable colon syndrome
 even with diarrhea."

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produces bland peristalsis-stimulating bulk. Through its
 enormous water-binding capacity (absorbing 50 times its own
 weight in water²) Mucilose holds its "bound water" during
 passage through the bowel producing soft, demulcent stools.
 Conversely, when taken with smaller amounts of water, Mucilose
 restores the normal water balance in the diarrheal phase of colitis
 by binding loose stool and reestablishing normal fecal colloid.

Mucilose should be taken with 1 or 2 glasses of water.

Laughlin, R. A.: *Jackson Clin. Bull.*, 13:83, Aug., 1951.

Gray, Horace, and Tainter, M. L.: *Am. Jour. Digest. Dis.*, 8:130, Apr., 1941.

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"...and don't forget the VITAMINS!"

Poor dentition, anorexia, and achlorhydria so common in elderly patients often limit vitamin intake and absorption.

A balanced vitamin preparation offers a reliable means of guarding against the development of avitaminoses.

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Speaking Frankly

Fee Splitting

Sms: The author of your series on fee splitting has taken a very partial attitude, but there *are* a few words of truth in one of the articles. I refer to the passage that discusses the case of a general practitioner whose patient underwent special surgery. Here's what the writer says: "The family doctor . . . did all the pre-operative diagnostic work . . . made most of the arrangements . . . [and] visited the patient daily." Yet the surgeon pocketed the entire \$500 operation fee.

Was it fair *not* to split the fee in this case?

M.D., Pennsylvania

Sms: I have just read the article on fee splitting in May MEDICAL ECONOMICS, and I think it is the finest analysis of the principles involved that has ever been written! I am delighted that you have the courage to print it.

Paul R. Hawley, M.D., Director
American College of Surgeons
Chicago, Ill.

Army for the D.O.'s?

Sms: In many states osteopaths are allowed to practice medicine legally. In several small communities in

Oregon, they are so entrenched that there is neither room nor work enough for M.D.'s. If the public wants the sort of care they get from osteopaths—instead of good medical care—they will get it. And if they *do*, then they should stop blaming the medical profession for the so-called "doctor shortage." I suggest that osteopaths be included in the count when another survey of doctor-distribution is made.

And while we're counting state-licensed osteopaths, we should count out a few for military service. Why should the Government play favorites and leave the osteopaths at home to reap a harvest, as they did during the last war?

C. A. McNeely, M.D.
Drain, Ore.

Downspout Dadoes

Sms: I have felt for some time that the "full service" concept of some Blue Cross and Blue Shield contracts is responsible for many of the abuses—and misunderstandings—that arise under these contracts. To illustrate what sometimes happens when you agree to replace a loss at "full" value, I have composed the following modern fable:

Once upon a time, a carpenters' guild decided to sell fire insurance

AVERAGE PENICILLIN BLOOD LEVELS —

The above graph compares penicillin blood levels with Injection BICILLIN 600 and procaine penicillin, aqueous suspension. (20 adults) Note the substantial prolonged penicillin blood level concentrations produced with Injection BICILLIN 600

Announcing . . .

A new and truly long-acting penicillin compound

INJECTION
BICILLIN*

Benzethacil

N,N'-dibenzylethylenediamine dipenicillin G



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Effective parenteral penicillin prophylaxis
and therapy with:

- slow absorption
- fewer injections
- less trauma
- lower cost

Produces remarkably extended blood levels: 1 injection 600,000 units in Tubex provides demonstrable penicillin levels in children for 14 days or more.

Ideal for use in rheumatic fever prophylaxis—particularly important in services which treat large numbers of patients.

Adequate single injection therapy—whenever penicillin protection is desired—is now available with Injection Bicillin.

Stable—for at least 18 months if stored at 59° F. temperature.

Supplied—Injection Bicillin 600 (600,000 units per Tubex®).

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Wyeth Incorporated, Philadelphia 2, Pa.

with the understanding that an insured house would be replaced if it burned down. Before long, houses were burning down at an unusual rate, and the guild members found themselves disagreeing with their subscribers about the construction details of the new houses. Strangely enough, all the subscribers wanted the mahogany flooring and expensive paneling that, they insisted, they'd had in their old houses.

When the work started, the subscribers began to complain, too, that there was considerable difference in the quality of the work done by different carpenters. And they added that the carpenters were disposed to charge extra for putting dados on the downspouts. Even when it was pointed out that such extra charges were permitted by the fine print in an obscure part of the contract, the subscribers were still not satisfied.

Moral: An indemnity slightly less than the loss fits human nature better than a full-service contract with reservations.

Francis S. Adams, M.D.
Pueblo, Col.

Careless Omission

Sirs: In a recent news column you quote an American Hospital Association survey of the "most frequent" charges for hospital services in 1951. Among those listed is the following: "X-ray of gastrointestinal tract (complete study, with or without fluoroscopy), \$25."

A gastrointestinal examination of

any type done without fluoroscopy is not worth a nickel of anyone's money—as I believe any radiologist will maintain to his dying breath. There may be, among your readers, a few who are so uncritical as to take this careless phrase as a guide to their own performance.

It is regrettable enough that current practice condones the inclusion of *medical services* in hospital charges; but it is doubly regrettable that such carelessness as the omission of fluoroscopy can be tolerated in this exacting type of study.

James B. Haworth, M.D.
Salem, Ore.

See Here, Professor

Sirs: As a country doctor, I must take issue with the eminent Professor Seymour Harris of Harvard University, who presented such a unique idea in March *MEDICAL ECONOMICS* ["Medical Education, Self-Supporting?—Why Not?"].

Professor Harris seems to believe that *only* doctors benefit from the medical schools and that, therefore, they alone should be responsible for financial aid to these institutions. Actually, medical education is for the benefit of *all* people, and the burden of supporting it should not be placed on the shoulders of one group alone.

Nels N. Sonnesyn, M.D.
Le Sueur, Minn.

Sirs: The suggestion from Seymour Harris that doctors pay back 2

the convenience in broad-spectrum therapy

Easily swallowed, sugar-coated Terramycin tablets introduce new flexibility in prolonged courses of administration and are particularly adapted to effective, well tolerated therapy among patients preferring tablets to other oral forms.

250 mg. tablets, bottles of 16 and 100;

100 mg. and 50 mg. tablets, bottles of 25 and 100

Terramycin tablets

ANTHONY J. L. B. 1968



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RELIEVE ITCHING due to IVY POISONING and INSECT BITES

To put a quick stop to pruritic affections of the skin and minimize dangers of secondary infection from scratching, prescribe CALAMATUM (Nason's) — a non-greasy cream embodying Calamine with Zinc Oxide and Campho-Phenol in an adherent base which requires no rubbing. It's the modern, more effective form of calamine lotion.

PROTECTIVE, DESICCANT MILDLY ASTRINGENT

CALAMATUM (Nason's) offers these extra advantages: the tube is easy and safe to carry; applications can be renewed anywhere at any time; no bandaging is required; it dries at once and will not rub off or soil clothing — features particularly effective in the treatment of children.

The use of CALAMATUM (Nason's) is not restricted to Summer. It is fast becoming the anti-pruritic of choice for the relief of itching and discomfort due to cold sores and other vesicular eruptions the year-round.

*Ethically distributed in 2-oz. tubes
by prescription druggists
or order direct from:*

TAILBY-NASON Co., Boston 42, Mass.

Send for sample

CALAMATUM

(NASON'S)

cent of their incomes to their medical schools strikes me as an excellent idea. But his plan is much too limited.

I propose that economists like Professor Harris pay back 3.75 per cent of *their* incomes to the schools that trained them. And future presidents of Bethlehem Steel should kick back at least 4.27 per cent of *their* lifetime incomes.

To make the process truly democratic, why not require every patient who phones between 5 P.M. and 5 A.M. to pay 0.3725 per cent of his life income to the doctor?

J. C. Olson, M.D.
Ogden, Utah

Anti 'Anti-Hospital'

SIRS: I was appalled at the attitude reflected in a letter, in a recent issue of MEDICAL ECONOMICS, entitled "Anti-Hospital."

Dr. Sherwood, the writer, certainly has a right to express his opinion, but I think it's unfortunate that any member of our profession should try to split us into pro-hospital and anti-hospital groups. His suggestion that "anti-hospital delegates" should be sent to state society meetings indicates a destructive and narrow type of thinking. It may seem trivial to say that hospitals are as essential to doctors as doctors are to hospitals but it's true.

I agree with Dr. Sherwood that the problem of doctor-hospital conflicts does exist, but the solution must be based on mutual understanding and not on puerile suggestions like the recommendation that

selective control
of Gastrointestinal Spasm
Mesopin

(brand of homatropine methyl bromide)

When pain, heartburn, belching, nausea,
or unstable colon are due to
gastrointestinal spasm, Mesopin provides
an effective means for prompt relief.
Its selective antispasmodic action controls
spasticity with virtual freedom from the
undesirable side effects of atropine or belladonna.
Thus, Mesopin is relatively safe for the relief of
gastrointestinal spasticity, such as pylorospasm,
cardiospasm, spastic colon, and biliary spasm.

Mesopin—2.5 mg. per teaspoonful of
elixir or per tablet. Mesopin-PB*—
2.5 mg. Mesopin and 15 mg.
(1/4 gr.) phenobarbital per
teaspoonful of elixir
or per tablet.

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*PB abbreviated designation

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chromic sutures

are chromicized with two baths
for dependable absorption



Better control of suture absorption rate is now possible with the new Curity method of two-bath chromicizing after the strand has been formed. The first bath *does not* "tan" but permeates the strand. The solution used in the second bath combines with the molecules of the first, within the strand, achieving total even chromicization from rim to center. As a result absorption is similarly uniform.



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11 VITAMINS including both types of B12
8 MINERALS including larger amounts of CALCIUM
in 1 small tablet

Suggested Daily Dose	as a Dietary Supplement	In Geriatrics	Therapeutic Administration Inc. Pregnancy
	1 Tablet	2 Tablets	3 Tablets
VITAMIN A	5,000 USP Units	10,000 USP Units	15,000 USP Units
VITAMIN D	400 USP Units	800 USP Units	1,200 USP Units
VITAMIN C	50 Mg.	100 Mg.	150 Mg.
VITAMIN E	0.65 Mg.	1.7 Mg.	2.55 Mg.
VITAMIN B1	3 Mg.	6 Mg.	9 Mg.
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NIACIN AMIDE	15 Mg.	30 Mg.	45 Mg.
PANTHENOIC	4.3 Mg.	8.6 Mg.	12.9 Mg.
FOLIC ACID	0.5 Mg.	1 Mg.	1.5 Mg.
VITAMIN B12*	1 Mcg.	2 Mcg.	3 Mcg.
CALCIUM	250 Mg.	500 Mg.	750 Mg.
PHOSPHORUS	190 Mg.	380 Mg.	570 Mg.
IRON	10 Mg.	20 Mg.	30 Mg.
COPPER	0.5 Mg.	1 Mg.	1.5 Mg.
IODINE	0.075 Mg.	0.15 Mg.	0.225 Mg.
COBALT	0.05 Mg.	0.1 Mg.	0.15 Mg.
ZINC	0.1 Mg.	0.2 Mg.	0.3 Mg.
MANGANESE	0.3 Mg.	0.6 Mg.	0.9 Mg.

*30% U.S.P. Crystalline

*50% B12 Concentrate

Available at all pharmacies

LOW IN COST TO PATIENTS

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NEW
AN OUTSTANDING PRODUCT
FOR OBESITY CONTROL

ALL 5 FACTORS IN 1 SMALL CAPSULE

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Amvicel

To inhibit appetite, each capsule contains:
5 mg. dextro amphetamine sulphate

To effect nervous stimulation:
1/4 gr. phenobarbital

To supply needed bulk:
200 mg. methylcellulose

To supply protective amounts of nutritional factors:
10 vitamins and 8 minerals

Low in cost to patients:
Approximately 4¢ per capsule

AVAILABLE AT ALL PHARMACIES

Stuart

county medical societies try to "de-
 cent all pro-hospital men nominated
 as state delegates." Certainly, the
 practicing physician and the hospi-
 tal administrator will not see eye-to-
 eye on every issue, but at least let us
 learn to disagree agreeably!

Hartman A. Lichtwardt, M.D.
 Detroit, Mich.

Sms: The letter entitled "Anti-Hos-
 pital" is a brilliant portrayal of the
 attitude that threatens to banish our
 hospitals and the private practice of
 medicine from the realm of free en-
 terprise. Imagine the delight with
 which the advocates of Government
 medicine will view this evidence of
 internecine strife.

Let's not talk or think about pro-
 hospital and anti-hospital people.

Let's all concentrate on being pro-
 patient. The patient is the guy who
 gets whipsawed when there is fric-
 tion between the hospital adminis-
 tration and the medical staff.

For the hospital in which Dr.
 Sherwood works, I suggest a joint
 committee to study and arbitrate the
 causes of friction.

Lucius W. Johnson, M.D.
 San Diego, Calif.

Not Money-Minded

Sms: It is my habit not to charge if
 I refer a patient to a specialist with-
 out having started treatment. Al-
 though I lose a fee in such cases, I
 feel that this policy bears rich di-
 vidends in public relations.

For one thing, it proves to the pa-
 tient that his doctor is not money-

PRESCRIBE WITH CONFIDENCE

Freeman BACK SUPPORTS

Working closely with the medical profession for more than 60 years, Freeman has developed a line of surgical supports from which you can select and prescribe with complete confidence.

The Freeman line of corset-type back supports includes models which provide supportive and conservative measures in any required degree up to almost complete immobilization. In addition to correct design and quality construction Freeman supports embody many advancements and improvements. Linings and stay covers are cushioned for comfort and side-laced back supports have a new and exclusive self-smoothing, non-wrinkle fly.

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minded. Also, it educates him to his personal physician first for every condition. Thus he isn't likely to consult a specialist in the wrong field for his particular case. Too many patients ask themselves, "Why see a G.P. and pay an extra fee when I probably have to go to a specialist anyhow?"

Federick E. Ems, M.D.
Petaluma, Calif.

Chiroprody Clarified

SIRS: A letter you published from a chiroprodist contains the statement that "Our profession is recognized by the A.M.A. on a par with dentistry."

Do you believe this is true?

This same letter also says, "During World War II the Navy commissioned chiroprodists in the Hospital Corps."

Do you believe that this also is true?

Such false statements are detrimental to the interests of good medicine and ethical medical practice.

William M. Cason, M.D.
Atlanta, Ga.

To set the record straight, MEDICAL ECONOMICS has asked both the A.M.A. and the Navy for clarification of the chiroprodist's status.

Says Dr. Ernest B. Howard, assistant secretary of the A.M.A.: "The chiroprodist meant that the American Medical Association does not consider chiroprody a cult, he was correct. If he meant, however, that physicians view chiroprody and dentistry as professions for which the

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unit...at a cost far lower
than you'd expect



GE OFFICE-PORTABLE X-RAY UNIT broadens your diagnostic service to your patients

So compact it occupies little more space than a typewriter on your desk. Powerful enough to produce pelvic radiographs in two to six seconds... hands, wrists, elbows in $\frac{1}{4}$ to $\frac{1}{2}$ second. The GE Office-Portable X-Ray Unit is an invaluable addition to any successful practice.

Available at a moment's notice, the unit plugs into any 115-volt outlet. Tube head rotates horizontally and vertically for quick, easy examinations.

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For out-of-the-office use, you can fit this unit into its 21 x 14 x 9 inch luggage-type carrying case in a few seconds — make x-ray examination *whenever, wherever you choose.*

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You can put your confidence in —

GENERAL  ELECTRIC

same qualifications and training are necessary, he was incorrect. Certainly there is a definite place for chiropody just as there is for dentistry and medicine."

Says Capt. A. H. Staderman of the Navy's Bureau of Medicine and Surgery: "During World War II, the Navy did not commission chiropodists in the Hospital Corps of the Regular Navy or the Naval Reserve. A limited number of Doctors of Chiropody were commissioned in the Naval Reserve with a classification of Hospital Specialist, and their services were utilized by the Medical Department of the Navy."

Sirs: I was greatly interested in the letter you received recently from a chiropodist.

In the industrial concern where I am assistant medical director, we have a weekly foot clinic conducted by a pleasant, well-trained, and ethical young chiropodist. He has been conducting this clinic for about eight months now, and he has performed a wonderful service for us by making our employees more efficient in their work.

I feel that chiropody has much to offer the medical profession, especially in industrial medicine. If the chiropodists will take on the job of stamping out the beauty-parlor and back-room practitioners in their midst, they may well assume a status equal to that of dentists. And that is as it should be.

Norman Boyer, M.D.
Brevard, N.C.

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<p>GARFIELD Protoscopic Table</p>  <p>The best in examining, treatment and surgical tables.</p>	<p>MORGAN Urological Table</p>  <p>Exact positioning for E.E.N.T., GYN, Proctological, GU or general work.</p>
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under
pressure

Relief of spastic pain and distress...easing of tension

Worry, anxiety, fear — such "pressures" often account for visceral spasticity. To offset them, Trasentine-Phenobarbital provides mild sedation — as well as effective spasmolysis, rapid relief of pain.

Whenever you suspect a psychosomatic factor in visceral spasm, Trasentine-Phenobarbital is a logical prescription. Each tablet contains 50 mg. Trasentine hydrochloride and 20 mg. phenobarbital. Bottles of 100 and 500. Ciba Pharmaceutical Products, Inc., Summit, New Jersey.

Trasentine-Phenobarbital

(and of aliphentol)

Ciba

What to look for in a room air conditioner

A room air conditioner should do many things beside cooling. Many of these requirements are not generally understood. Consequently, the average purchaser has no yardstick of value. Now, Carrier has prepared a new Buyer's Guide that gives you 18 points to look for before you buy. It will enable you to make a wise decision. It will help you get more for your money. Your Carrier dealer will be glad to show this Buyer's Guide to you in his showroom or bring it to your office.

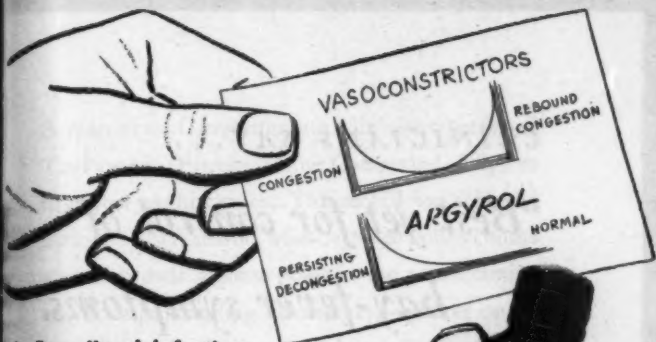


The beautiful Carrier Room Air Conditioner— built by the people who know air conditioning best

What should a good room air conditioner do? The Carrier Room Air Conditioner does it! It keeps you cool. Wrings excess moisture from the air. Gives you draftless air circulation and ventilation. It keeps your office clean and quiet. It takes little space, is easy to install and operate. But be sure to get the right size! It's easy to do when you buy a Carrier, because Carrier gives you more models to choose from. Call your Carrier dealer. He's listed in the Classified Telephone Directory.



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ARGYROL provides

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Demulcent Properties •
Computability with
Systemic Antibiotics**



In the treatment of para-nasal infection, local therapy remains of paramount importance. Inadequate drainage from closed spaces makes local therapy a necessary component of successful treatment. The bacteriostatic and physical properties of ARGYROL help overcome infection, promote drainage and provide decongestion without rebound.

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be sure to prescribe
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Decongestion and Relief without Rebound

Decongestion without Dysfunction

—the medication of choice in treating para-nasal infection

Made only by the

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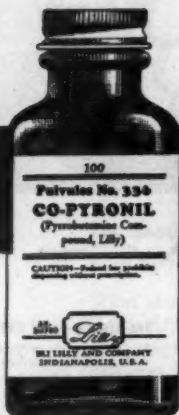
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Its Three-Fold Effect

1. Decongests without irritation to the membrane and without ciliary injury.
2. Definitely bacteriostatic, yet non-toxic to tissue.
3. Stimulates secretion and cleanses, thereby enhancing Nature's own first line of defense.

CLINICIANS SAY...

*"Best yet for control of
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Each pulvule contains:

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| 'Pyrnil' | 15 mg |
| (Pyrrobutamine, Lilly) | |
| 'Histadyl' | 25 mg |
| (Thenylpyramine, Lilly) | |
| 'Clopane Hydrochloride' ... | 12.5 mg |
| (Cyclopentamine Hydrochloride,
Lilly) | |

A majority of investigating clinicians preferred 'Co-Pyronil' (Pyrrobutamine Compound, Lilly) to any other antihistaminic. This record was achieved during the 1951 season, when ragweed pollen counts soared to their highest point in the antihistamine era. Four outstanding advantages—quicker onset, better control of symptoms, longer-lasting relief, and fewer side-effects—were repeatedly noted. Also, patients liked the convenience of fewer doses—usually only one or two capsules morning and night:

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'Co-Pyronil'

(PYRROBUTAMINE COMPOUND, LILLY)

QUOTANE*

... topical anesthetic

in "summer dermatoses"

Poison Ivy
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- 'Quotane' provides immediate and prolonged relief in the long list of itching and burning conditions so common in spring and summer.
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'QUOTANE' OINTMENT—for dry lesions

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the purging parent...

She boasts of
keeping the
poor child's
bowels
"wide open."

Instead of keeping the youngster healthy, she is establishing a laxative limp in the digestive tract.

Turicum, giving *lubricoid action without oil*, affords sane therapy without irritating the bowel.

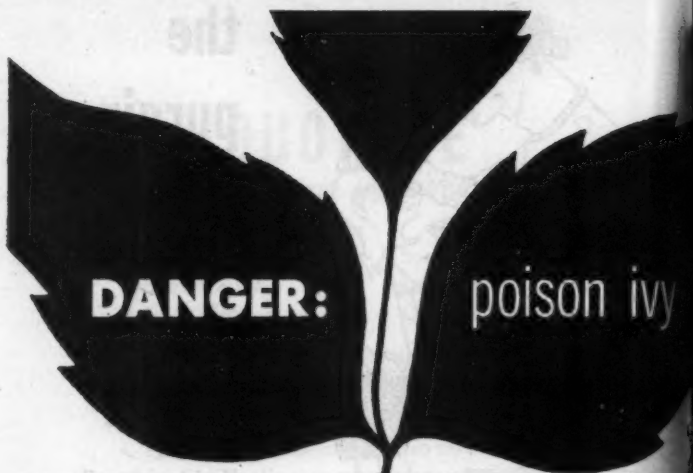
Turicum is not a one-dose cathartic. It is a treatment which, taken over a period, helps restore a gentle, symptomless, normal bowel function.

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MORE DANGER:

Phenol¹ (as in calamine c phenol) and the antihistaminics may cause irritation or sensitization. This danger is avoided by using bland Calmitol Ointment, the antipruritic "preferred because of its freedom from phenol, cocaine, cocaine derivatives and other known sensitizing agents"².

Prevent ivy poisoning with the Calmitol Ivy Leaf Service. Write for a free supply to

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1. Underwood, G. B.; Gaul, L. E.; Collins, E., and Mosby, M.: J.A.M.A. 130:249, 1946. 2. Lubowe, I. I.: New York State J. Med. 50:1743, 1950. 3. Goodman, Herman: J.A.M.A. 129:707, 1945.

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Pruritus is effectively controlled with Calmitol. Its antipruritic ingredients, camphorated chloral, hyoscyamine oleate and menthol (Jadassohn's Formula), as distinguished from inert calamine³, block itching by raising the impulse threshold of skin receptor organs and sensory nerve endings.

The lanolin-zinc oxide-petrolatum base of Calmitol Ointment protects the site of discomfort from irritation.



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the bland antipruritic

When the condition calls for IRON



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WITH CONSTANTLY GROWING clinical recognition of iron deficiency anemia, there is increasing need for an effective, well tolerated and convenient form of pharmaceutical iron.

Based on the established efficacy and good utilization of ferrous sulfate in an acidulous vehicle, FER-IN-SOL® provides ferrous sulfate in a pleasant citrus flavored solution.

Concentrated, for convenient drop dosage, FER-IN-SOL contains 125 mg. ferrous sulfate per cc. Each 0.6 cc. dose supplies about 75 mg. ferrous sulfate.

FER-IN-SOL's piquant iron flavor blends perfectly with fruit juices. Both infants and children take FER-IN-SOL willingly.

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0.6 cc. = 75 mg.
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When you have the problem of restlessness and crossness
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When you have the problem of insomnia in children with colds,
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Available, also: elixir Eskaphen B with Belladonna, for use in patients
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Sidelights

Tax Informers

The curious case of the late Dr. Sidney Lange, a Cincinnati radiologist who fell some \$3½ million behind in his income taxes, illustrates once again how vulnerable doctors can be. Dr. Lange had made a killing in the wartime stock market, and he couldn't keep word of it from getting around. Eventually it got to the Revenue Bureau. As a result, the informer who tipped off the tax agents may collect as much as 10 per cent of their take.

Similar tips about other doctors are not at all uncommon, the tax people say. The source may be a dissatisfied patient, a resentful cultist or colleague, sometimes just a plain busybody. The tip may be nothing more elaborate than a note reading thus: "I hope Dr. Blank of this town is paying all the taxes he's supposed to. I've noticed he makes a great effort to collect all possible fees in cash."

If the note is not from a known crank, it will be routinely investigated. This applies, incidentally, even to unsigned letters.

"All we need," one Revenue Bureau spokesman has said, "is a hint that someone is not reporting his full income. If the hint is well founded,

we can generally get enough evidence to prove it."

Happily, most such tips turn out to be *not* well founded. The fact that they crop up at all, however, is something that no doctor can afford to ignore. They serve as a useful reminder that medical men are too much in the public eye for their scale of living, their spending habits, even their private business affairs to escape critical notice.

Diagnosis by Machine

Diagnostic tests are fine things—but not necessarily as fine as a careful going-over by a good diagnostician.

People need to be reminded of this from time to time. One helpful reminder may be the story related recently by Dr. Samuel B. Hadden of Philadelphia:

The young son of an old Philadelphia family came down with convulsive seizures. A competent local neurologist, called in by the family doctor after careful investigation, became convinced that they were hysterical in nature. He began using psychotherapy, with highly successful results. Within a short time, the convulsions ceased.

Some weeks later, another member of the family read a popular

This Simplified
Dosage Schedule for
Rapid Subjective Relief
in

Hypertension



VERILOID[®]

BRAND OF ALKAVERVIR

Out of the vast clinical experience that has accumulated from the increasing use of Veriloid has come a simplified dosage schedule which rapidly produces relief from the distressing discomfort of hypertension. Within a short period, patients volunteer that they "feel better," even before the blood pressure begins to drop.

Here is the new daily dosage schedule which proves satisfactory for initial therapy in 9 patients out of 10:

- 1st Dose: After breakfast..... 2 mg.
- 2nd Dose: 6 to 8 hours later..... 2 mg.
- 3rd Dose: 6 to 8 hours thereafter..... 2 to 3 mg.

According to this plan, the second dose is taken about two hours after the noon meal, the third dose about two hours after the evening meal.

This schedule simplifies dosage calculation, is quickly productive of clinical results, minimizes nausea and other side actions. Dosage should be increased by 1 mg. per day every third day until a satisfactory blood pressure drop is achieved. The evening dose is usually 1 or 2 mg. larger than the other two doses of the day. For the average patient, a daily dose of 9 to 15 mg. proves effective and rarely causes side actions.

Veriloid, brand of alkavervir, is a unique alkaloidal fraction of *Veratrum viride*. It is indicated in the treatment of all grades of essential hypertension and in hypertension of renal origin. Available on prescription at all pharmacies, in 1, 2, and 3 mg. tablets.

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When over-indulgence in food and drink causes your patients to suffer from acid indigestion, they will appreciate the quick, lasting relief offered by BiSoDoL. This dependable antacid reduces excess stomach acidity—actually protects irritated stomach membranes. And it is pleasant tasting—well tolerated. For an efficient antacid why not recommend

BiSoDoL®
tablets or powder



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magazine article that advised electro-encephalography in all such cases. He asked the attending neurologist about it. The latter, pointing out that the boy had been well for some time, expressed doubt that it would be worth-while in this instance. So the family called in another neurologist, who finally agreed to the desired procedure.

In the middle of an elaborate series of tests, the patient's convulsions started again. He was hospitalized for six weeks. When at last he was finally released, there were still no positive findings, and the family was told he'd simply have to "snap out of it by himself." Cost of this fruitless hospitalization: a whopping \$3,100.

The human element in diagnosis used to be universally respected. Whatever we can do to restore that respect may well take some pressure off the patient's pocketbook nerve.

Bad Publicity

Suppose you discover that a news story unfavorable to local medicine is about to break. Do you bend your energies toward trying to quash it? Or do you simply see that the reporter has his facts straight?

Doctors in Phoenix, Ariz., have found that "bad publicity" often brings good results. So they've made it their policy not to interfere when a reporter starts probing some medical trouble spot. They merely use their influence to have the facts fairly presented.

Not long ago, a local citizen died

for

smooth

action

GREATER PRESSURE

without backfire

Each VIM piston is carefully ground and precision-fitted to its own barrel. Each completed assembly is tested to withstand 20% to 40% greater pressure than government standards require. That's why a VIM syringe is guaranteed to give you velvety-smooth action without backfire.

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WHEN YOUR PATIENTS NEED

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Laurium[®]

—combines iron in the form of readily absorbed, well utilized, non-irritating ferrous gluconate plus folic acid, liver, and the vitamins B and C to aid iron absorption and help overcome associated nutritional deficiencies.

COMPLETE
POTENT
WELL TOLERATED

Whittier
LABORATORIES
Chicago 11, Illinois

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after waiting several hours for treatment at the county hospital clinic. Such delays had long been quite common, but nothing had ever been done about them. Nothing, that is, until the news stories broke.

Members of the local medical profession might have been able to hush up the incident to some extent. But they took the view that they shouldn't—and didn't. A few days later, the hospital hired several additional doctors so that the clinic would be properly staffed.

Bad publicity? Perhaps. But it produced constructive results. Isn't that what all doctors want?

Teachers First

Color television has apparently proved its value as a teaching aid in medical schools. The University of Kansas Medical Center, for example, has invested \$35,000 in a color TV set-up that will carry daily surgical demonstrations for the benefit of students. Other schools may follow suit before long, with the result that a lot of money may be spent on this comparative luxury.

There's much that is good about this new development. Yet, considering the precarious financial position that some schools are in, we can't help drawing a parallel between (1) a budget-strapped school that buys such expensive equipment, and (2) a patient who "can't afford" to pay his doctor bill, but who nevertheless has a TV set in his living room.

Many schools today find it hard

HALEY'S M-O[®]

*Antacid
Laxative
Lubricant*



HALEY'S M-O is a homogenous, pleasant-tasting emulsion combining the antacid and laxative properties of Phillips' Milk of Magnesia with the lubricating action of Pure Mineral Oil.

As an antacid, Haley's M-O brings fast relief from the symptoms of gastric hyperacidity.

As a laxative, the minute oil globules are thoroughly distributed and mixed with the intestinal contents . . . resulting in gentle, demulcent and thorough evacuations without leakage.

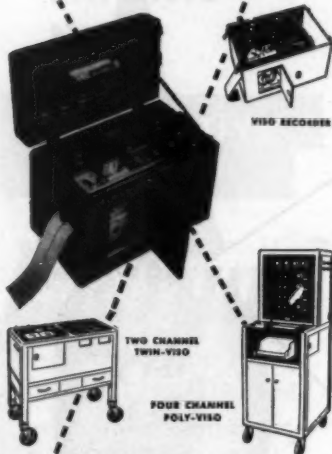
Haley's M-O is especially desirable for bowel irregularities associated with pregnancy and hemorrhoidal conditions.

DOSAGE:

1 to 2 tablespoonfuls
before retiring.

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The Viso-Cardiette started something



Shortly after the Viso-Cardiette was introduced and accepted as a clinical 'cardiograph', many were asking also for an instrument that would record more than one phenomena simultaneously, and do so via the same basic design advantages of the Viso. In answer Sanborn multiplied the Viso by four, so to speak, and came up with the four-channel Poly-Viso Cardiette—soon to follow it, in the same manner, with the two-channel Twin-Viso Cardiette.

Some wanted a less elaborate Viso, and the Viso Recorder was designed. And, the field of Industry also found good uses for all this recording equipment.

Taken as a common denominator of all the various Viso models in use today, one-channel Sanborn systems now total nearly 20,000!

Yes, the Viso-Cardiette started something!

Further information and descriptive literature will gladly be sent on request.

SANBORN CO.

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to keep their professors from leaving for the greener fields of private practice. These schools might pay their "doctor bill"—in the form of higher salaries for teachers—before they go completely overboard on things like television.

Worst Fault

Four doctors who often lunch together decided not long ago that it would be a good idea if each of them described what he considered his worst professional fault. One of the participants has since relayed to me an account of the discussion. It was something like this:

The first doctor admitted to a dangerous fondness for snap diagnosis. "I guess there are times," he said, "when I miss some symptoms I should have considered before starting treatment."

The second doctor conceded that his fees might be unduly high in some cases. "I just don't have the time to look into everyone's economic status," he added.

The third doctor was quite blurted about his worst fault. "Unnecessary operations," he said. "I'm not at all happy about the number of times I've taken out an appendix that turned out to be normal."

The fourth doctor, however, refused to talk. This raised a good-natured howl from the other three, and they pressed him to make a clean breast of it. Finally he broke down.

"All right, fellows," he said. "My worst fault is gossip—and I can hardly wait to get out of here."

For Vaginal Tract Infections

AVC

IMPROVED
(Allantoinide VAGINAL CREAM)

In
**TRICHOMONIASIS
MONILIASIS
MIXED INFECTIONS**

AVC Improved is a time tested formula for the treatment and prophylaxis of vaginal tract infections.

QUICK RELIEF • EASILY APPLIED • NON-IRRITATING

TRICHOMONICIDAL

It Kills Trichomonas—

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It Kills Fungi—

Especially monilia.

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It Kills Bacteria—

Especially certain gram-positive and gram-negative cocci and bacilli.

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It Kills Odors—

Especially objectionable and unpleasant odors.

Because . . .

AVC Improved re-establishes the normal flora and the normal pH.

Because . . .

AVC Improved is indicated in a wide range of infections of the exocervix, vagina and vulva:

- Trichomoniasis
- Monilia
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Because . . .

AVC Improved suppresses secondary invaders . . . an important therapeutic goal.

IT WORKS!!!

Use AVC Improved in your most stubborn cases. The results will please you, and your patients will be grateful.

Formula: 9-Aminoacridine Hydrochloride 0.2%, Sulfanilamide 15%, Allantoin 2%, specially prepared buffered water-miscible base.

Available: in 4 ounce tubes, with or without applicator.

Literature supplied on request.

THE NATIONAL DRUG COMPANY

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Over Half a Century of Service to the Medical Profession



How to keep your hands in good condition

More and more Doctors are finding that the use of mildly medicated Noxzema Cream after scrubbing hands helps keep them soft, smooth and in excellent condition.

Here's why — Noxzema's bland medication not only soothes any irritation but supplies a light film of oil-and-moisture to the skin's outer surface. It's so clean to use, too — doesn't leave hands sticky. Greaseless... takes only a second to apply. Make it a practice to rub in a little Noxzema every time you wash your hands.

For your information: Regular Noxzema Skin Cream is a modernization of Carron Oil, fortified by

adding Camphor, Menthol, Oil of Cloves and less than 1/2% of Phenol in a greaseless, solidified emulsion. Its reaction is almost neutral—the pH value being 7.4.

If you haven't tried Noxzema Skin Cream, we will be happy to send you a generous complimentary jar. Just drop a card to Dept. X, Noxzema Chemical Co., Baltimore 11, Md.

P.S. New shave comfort!

You'll enjoy Noxzema Brushless Shave Cream—the shave that's so different—that's medicated—that relieves razor scrape and soreness... leaves your face feeling wonderfully smooth and comfortable. For your next shave, get Noxzema Brushless Shave Cream—tube or jar.

Use and prescribe the **NEW** Johnson's
ELASTIC BANDAGE (Rubber Reinforced)

★ **MORE S-T-R-E-T-C-H**

★ **MORE SNAP-BACK**

THAN CONVENTIONAL ELASTIC BANDAGES

★ **Natural flesh color**

The lively rubber threads of this cool, lightweight bandage provide the optimum amount of support with a lesser degree of tension than is normally required.

Compare its elasticity, strength, weight and contour conformity with the elastic bandage you are now using. Women, especially, will like its *natural* flesh color.

Made by Johnson & Johnson—the most trusted name in Surgical Dressings for over 64 years.

Johnson's Elastic Bandage—Rubber Reinforced—may be applied with confidence whenever the use of an elastic bandage is indicated. Available at drug stores everywhere.



Available in 2", 2½", 3" and 4" widths.
All 5½ yds. long when stretched.

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Above—Polydactylism, feet. Face page, left—Polydactylism, hand right—Fungus infection, hands.

Review them...

before you show them

There are two sides to successful Kodaslide presentations. How you show your cases is important ... also what you show. That's why so many physicians and surgeons have a Kodaslide Table Viewer handy ... use it constantly to edit their slides as well as to show them to patients and colleagues.

Serving medical progress through Photography and Radiography

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Both a
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Review them...

**quickly, inexpensively with
Kodaslide Table Viewer 4X**

Both a projector and a screen, the "4X" has an efficient optical system. Kodak Day-View Screen brings out full brilliance of transparencies in a normally lighted room with the projected image enlarged more than four times. Convenient slide changing. Handy focusing knob. AC or DC, 100 to 125 volts. List price, subject to change without notice, \$49.50.

For further information see your Kodak photographic dealer or write:

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for more blood flow



Priscoline

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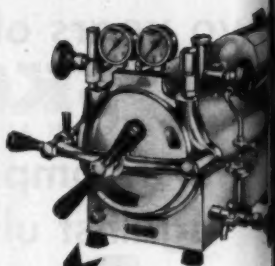
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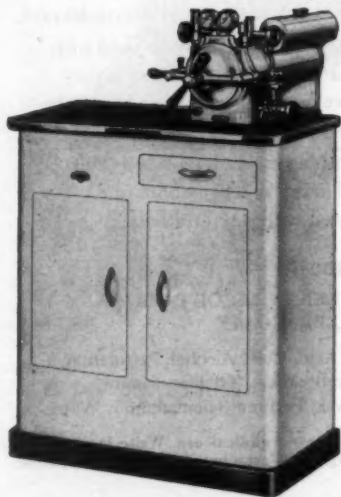
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1. Batterman, R. C.: *Modern Medicine*, 19:59, 1951.

2. Goodman, L., and Gilman, A.: *The Pharmacological Basis of Therapeutics*. The Macmillan Company, New York, 1941.

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1. Simonnet, H. Nutrition in Pregnancy, *Canad.M.A.J.*, 58:556, (June) 1948, p. 560.

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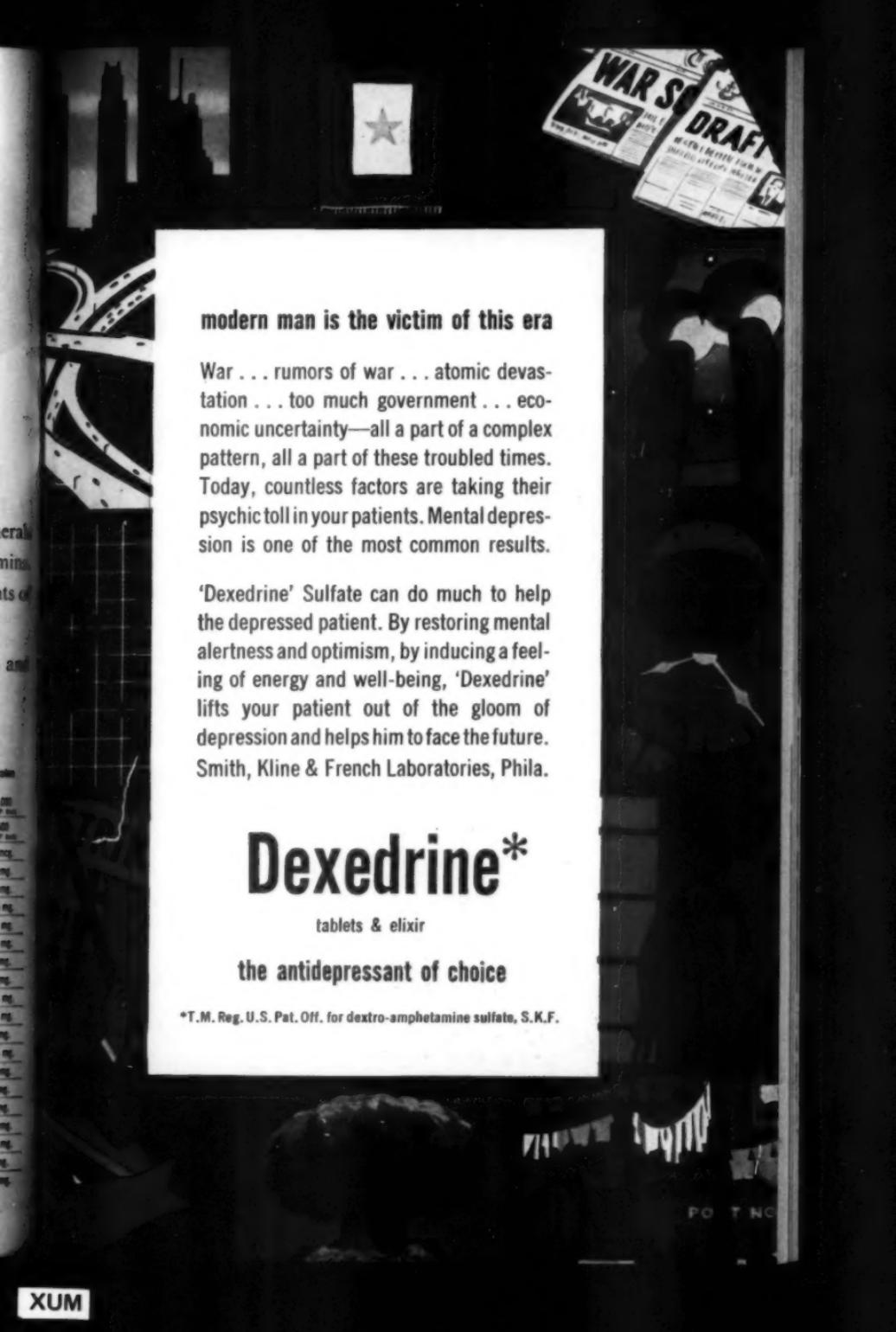


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Editorial

Patient's-Eye View

What are the causes of poor public relations? Doctors no longer need guess at them. Survey after survey has spotlighted such medical misdeemeanors as making patients wait, displaying an impersonal attitude toward them, and charging indefensible high fees.

But a related question remains unanswered: *Who* causes poor public relations?

Surveys don't tell us *which* doctors are responsible. But the following incidents may shed some light on the matter:

[A busy executive canceled several appointments to undergo a medical check-up. He was ushered into a drafty treatment room, told to strip to the waist—then left there untended for forty-five minutes.

[A young woman caught her fingers in a car door. She ran to the nearest medical office, brandishing a bloody hand. The secretary greeted her with these words: "Of course you realize there'll be a charge!"

[An elderly pensioner underwent an operation. Without checking his economic status, the surgeon billed him for \$300. This was exactly three times the man's total existing cash resources.

These incidents took place in California, New York, and Chicago. What do they have in common? Simply this: *The doctors were all men of top reputation, presumably skilled in the art of medicine.* And if men of this caliber inadvertently alienate some patients, we can safely assume that the rest of us do.

Which means that the question, "*Who* causes poor public relations?" must in all probability be answered:

YOU do. We ALL do. And it's time we cut it out.

The best safeguard against such lapses is an occasional patient's-eye view of yourself and your practice. We mean an appraisal by a management consultant, an efficiency expert, a business psychologist, or any qualified outsider in whom you have confidence. This sort of appraisal can root out professional habits that irritate people.

At least a few doctors, of course, have already profited by seeking an outsider's slant. One colleague of ours simply asked a friend in the public relations field to enter his office as a patient, then report on the results. As surveys go, this was strictly a quickie—it cost just \$75. But here are some of the irritants it uncovered:

1. There was insufficient privacy

throughout the doctor's office. Waiting patients were jammed close together at one end of the reception room. Worse, they could hear snatches of conversation from the doctor's inner sanctum.

2. There was friction between the doctor's receptionist and his technician; patients couldn't help noticing it. (The solution turned out to be a detailed job analysis, settling minor conflicts over duties and responsibilities.)

3. The receptionist had a brusque manner on the telephone. She was inclined to say flatly, "The doctor isn't in," instead of doing her best to sound helpful ("The doctor isn't in right now, but I'm expecting him soon. May I take a message?").

4. The doctor permitted frequent

interruptions during the consultation: incoming phone calls, questions from his receptionist, reports from his technician. The patient's reaction was apt to be, "Don't I rate undivided attention?"

5. The doctor tended to minimize his own services. "There's nothing to it," was a favorite expression of his. Which made the patient wonder, "Then why does he charge so much?"—even though the doctor's fees weren't at all out of line.

Such are the little things that patients generally notice but that doctors sometimes don't.

Do they exist in your own practice? The answer is probably yes. But you'll never know for sure until you arrange to acquire the patient's-eye view. —H. S. BAKETEL, M.D.



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"We'd better keep an eye on him!"

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As it turned out, the two men
(whom I'd never seen before) were
a revealing study in contrasts. The
first—I'll call him Dr. Bonham—im-
pressed me very favorably, though
his dreary reception room and in-
different secretary did not. As for
the doctor I'll call Malahan—well, I

A Psychologist Goes to the Doctor

*There are some perceptive
points on patient relations
from a trained observer*

A professional psychologist is like other patients when he has to see a doctor. He feels just as strange, as keyed-up, as apprehensive. Like everyone else, he reacts emotionally to the reception room, the receptionist, and the doctor.

But because of his special training, he may notice significant details that others miss. And he is more likely to spot the subtle reasons for his reactions—whether good or bad.

Not long ago, in applying for life insurance, I had to be examined by two separate physicians. As a psychologist, I couldn't help noting the differences between them and their methods; and I should like to pass my observations along, on the chance that other doctors may benefit by them.

As it turned out, the two men (whom I'd never seen before) were a revealing study in contrasts. The first—I'll call him Dr. Bonham—impressed me very favorably, though his dreary reception room and indifferent secretary did not. As for the doctor I'll call Malahan—well, I

was delighted with his reception room set-up but alienated by the man himself.

I arrived ten minutes early for my appointment with Dr. Bonham. In vain I looked around the small, crowded waiting room for someone to announce myself to. After nearly twenty minutes, his secretary drifted in. She nodded brusquely when I gave my name. Then she picked up some papers from her desk and left.

For the next half-hour, my annoyance grew. Nor was it eased by the atmosphere of the room. I sat on a hard, straight-backed chair, wedged tightly between other patients.

The magazines and ash trays were on a rickety table in the center of the room, just out of everyone's reach. Even worse, the available reading matter consisted of nothing but medical brochures—probably intended for the doctor's eyes alone. They dealt with such reassuring subjects as cancer of the cervix, Cushing's syndrome, and psychoses associated with the menopause.

For want of anything better, sev-

By David Rutherford

**The author, who writes here under a pen name, is a clinical psychologist on the staff of a state hospital in the East.*

eral patients were sampling these tidbits with a glazed look in their eyes.

Dr. Bonham, I decided, must work on the theory that his reception room is "good enough to get by." Yet with a little extra effort he could have magazine racks and ash trays placed conveniently near the chairs. And he could at least subscribe to a few of the popular periodicals. Patients in waiting rooms don't want to read steadily. They skim; they glance at pictures; then they turn restlessly to something else. They don't relish getting up each time and walking conspicuously to the middle of the room.

I began to wonder how successful—and how competent—was the doctor who had this poorly run office. Then I was called in to see Dr. Bonham, and soon my doubts vanished. Perhaps he saw the discontent in my face. Anyway, he instantly explained why I had been kept waiting.

"I'm sorry," he said. "I've been delayed by a couple of unexpected house calls. When these emergencies arise, I have to depend on my office patients to understand. If the emergency were in their families, I know they'd want the doctor to drop everything and come."

That explanation struck me as a good one. But why did he waste *his* valuable time on it? His assistant, I felt, should have been trained in the art of putting patients at their ease.

Curiously enough, a similar situa-

tion arose when I went to see Dr. Malahan. But *his* receptionist knew her job. She greeted me with a smile and immediately told me what was what:

"I'm sorry to have to ask you to wait. The doctor has had an emergency call and probably won't be back for half an hour. But if you have to talk to him right away, I'll try to contact him. Naturally I wouldn't think of making you wait if it hadn't been really serious."

In a good frame of mind, I sat down and looked around me. The room was spacious, its color scheme exhilarating. The walls were a green, with lighter green in the picture frames, lamp shades, and chair coverings. Here and there, touches of rose and yellow added a note of brightness.

Because the place was bright and interesting, I liked it better than the more expensive "decorator" kind of room, which, though designed to soothe, may seem merely vapid and aseptic. This may please some people; it anesthetizes me. I prefer a little stimulation.

Waiting Made Easy

In these circumstances, I didn't dream of protesting my wait. Dr. Malahan's receptionist had even made me feel a little noble: Thanks to my great and good patience, was sitting in a pleasant room, comfortably permitting the doctor to change in a life-and-death dash from somebody's bedside.

Her explanation, in fact, was psychologically perfect. She gave the patient credit for being inconvenienced. She gave him a definite idea of how long he would have to wait. She even implied that he was so important that he could summon the doctor if necessary. Hence, she had slipped in the bud any possible feeling of a shabby welcome.

In addition, she used another device to make waiting agreeable: She handed me a brief personal-history form and said, "If you'll just fill this out, it will save the doctor asking a good many questions."

Now that I think back, I doubt whether Dr. Malahan ever used, or even saw, my form. But answering the questions made me feel that I wasn't wasting my time. It was a neat piece of patient psychology, and I congratulate whoever thought of it.

Unfortunately, however, Dr. Malahan himself failed to make the bit with me that his receptionist did. Why? Well, in general, because he tended to treat me impersonally. He gave the impression that I was merely something to be examined routinely.

In the other office, Dr. Bonham, unlike his receptionist, had treated me as an individual. For example, I felt that he adjusted his manner to the sort of person I appeared to be.

This important difference between the two doctors came out in many little ways. Dr. Bonham, for instance, talked to *me*; he repeated my name

from time to time. He smiled now and then. When he required some physical action, he prefaced his request with a disarming remark like: "I'd appreciate it if you'd . . ." or "If you don't mind, will you . . . ?" or "This may seem a little silly, but it will help if you'll . . ."

He also told me *why* he wanted me to do these things. I'm apt to feel self-conscious, for instance, at having to jump up and down on one foot. It made me more comfortable when Dr. Bonham said something like, "Now I want to hear what your heart sounds like after a bit of exercise." The explanation took only a moment, and it increased my willingness to cooperate.

Dr. Malahan, on the other hand, was all business. After his first pleasant greeting, he assumed a "let's get on with it" attitude. He gave his commands gruffly, and it was up to me to respond without knowing why.

The two doctors also had different ways of framing their questions. As a result, I'm afraid that in some cases they got slightly different answers. Dr. Bonham sensibly repeated the questions as they were written on the insurance company form. "Have you ever had a venereal disease?" he asked. "Yes," I replied, and explained.

Dr. Malahan, for some reason, put each question in the negative. For example: "You've never had a venereal disease, have you?"

Now this is [MORE ON PAGE 189]

If They Want to Adopt a Child

Better tell your patients to apply to an agency, say the experts. Child placement is a full-time job—not your

By Otto F. Reiss

● One of Dr. Morgan's patients was an unmarried mother who had just given birth to a strapping baby boy. Unable to support the child, she begged the doctor to find a good home for him. By a happy coincidence, Dr. Morgan was the family physician of a childless couple who wanted to adopt a baby.

Taking what seemed an obvious step, the doctor arranged for the child's adoption. But what its new parents had managed to conceal from him was that their marriage was about to go on the rocks. You can guess the rest of the story: The little boy failed to rescue his new parents' marriage, as they had hoped

he would. Two years later, they were divorced; the wife married another man, who refused to adopt the child—and the baby was left homeless again.

Dr. Morgan had meant well. But he couldn't help feeling remorseful. "I should have known better," he kept telling himself.

Yes, he should have known better. The physician who matches an infant and a set of foster parents from within his own circle of patients and acquaintances is invariably playing with fire. Most doctors cautiously steer clear of the weighty legal and social problems involved in an adoption. But a surprising number of

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others, impatient with the delays and complications of adoption agencies, have taken it upon themselves to act as judge, jury, and star witness in adoption cases.

A recent study of 200 adoptions shows that only 46 per cent of the independent transactions have "good" results. (The results are considered good, of course, when a healthy, normally intelligent baby is placed in a stable, secure home.)

Says the Yale Law Journal, which favors stricter legal controls: "When adoptions are the product of independent placements, the blind frequently lead the blind. Good intentions are no substitute for trained

and experienced personnel. The interests of the child, as well as those of the natural and adoptive parents, may be lost . . . in a humanitarian mist."

The physician who arranges an adoption shoulders a threefold obligation: to the parent who gives up the child; to the child itself; and to the foster parents. "Of them all," says Obstetrician George W. Kosmak, "the interests of the . . . child must remain paramount, for the only sound goal in adoption is to find a suitable home for [it]."

If the foster parents are the physician's patients, he probably knows something about their health, age,

life expectancy, and finances. But how about their fitness as parents?

Says Father G. Howard Moore, of one of the Catholic adoption agencies: "The mere wish to adopt a child does not necessarily go hand in hand with the ability to fulfill the obligations and emotional demands of adoption. The skilled social worker is trained to discover whether a couple has these abilities."

According to some experts, the doctor who arranges for an adoption

is likely to make one great mistake. He gives too much weight to the interests of the aspiring foster parents. After all, he has been their family physician and knows that they want and need a child.

"But," says Roberta Andrews of New York's Spence-Chapin Adoption Service, "a baby isn't a therapy. He's an individual. Let's assume that the supposedly infertile couple, after adopting the child, is blessed with offspring of its own. Is the doctor sure the foster child will then continue to enjoy the same warmth and love it had before?"

And what about the fact that, whether they admit it or not, the adoptive parents want not merely a child but the *right* child? Maybe the physician can assure them that the baby has no visible physical defects. But can he do much more? Has he had enough time to study its natural parents and their background? Can he possibly tell whether in appearance and intelligence the baby will fit into the new family group?

Only a thorough, expert, and time-consuming check into the infant's antecedents can help prevent mismatched adoptions. The doctor seldom has the facilities to undertake such an investigation. The various social agencies, on the other hand, *do* have them.

From Dr. Samuel Karelitz, the pediatric consultant of a leading Jewish adoption agency, comes this warning: "If the doctor masterminds the placement, he's creating



"Heart specialist."

an irreversible situation. The foster family has no recourse anywhere if the child turns out defective. In about 5 per cent of our cases, various defects not observable at birth—such as congenital abnormalities of the brain or fatal metabolic disturbances—are detected at a later stage."

As an example of how his agency fulfills its obligation to the foster parents, Karelitz refers to a recent case in which, five months after the placement, it developed that the child was an epileptic. Not only were the parents permitted to return the child for ultimate placement in an institution, but the agency offered to let them adopt another.

Parents Anonymous

Most direct placements also violate the principle of anonymity, which Drs. Ruth Morris Bakwin and Harry Bakwin, writing in *The Journal of Pediatrics*, put as follows: "It is not advisable to have the adoptive parents meet the true parents. The child should not be told the name of his true parents nor their whereabouts."

A cruel dictum? It may seem so to the kind-hearted physician who has thought it his humanitarian duty to introduce mother and foster parents to one another.

But what if, later on, the natural mother yearns to see her adopted youngster? Can the adoptive parents deny her the right to do so? Authorities agree that visits of this kind may seriously endanger the success

of an adoption. In an agency-transacted adoption, the mother is never told the name of her child's new family.

Doctors Aren't Lawyers

Perhaps the greatest stumbling block on the road to satisfactory adoption is the law. Few doctors are aware of all its complications. Even fewer are equipped to grapple with them. Handling the legal side of adoption proceedings demands both skill and experience.

If the foster parents, left to their own devices, have failed to take the proper legal steps, there may be tragic consequences. The child, for example, may later find himself destitute, because he has no claim on his adoptive parents' estate. Or one or both of his natural parents may suddenly demand their baby's return.

According to Attorney Shad Polier, a national authority on adoption law, "In every state, the natural parents have the primary right to custody of the child. Consequently, at any time before adoption, they are likely to get the child back if they can prove that they are fit parents and that the child was surrendered under stress."

In addition, some states already have statutes providing that only the biological parents, the legal guardian, or an adoption agency may place a child. Therefore, in these areas it's actually illegal for a doctor to arrange an adoption. In Minnesota, not long ago, the Attorney

General investigated four physicians who had helped in the placing of children, and found grounds for the prosecution of two of them.

Agencies the Answer

For all these reasons, then, the doctor should avoid involvement. "Don't succumb to the temptation to do people a favor; refer all child placements to recognized adoption agencies." That's the unanimous advice of the experts. They have handled thousands of cases and have studied the effects of "good" and "bad" placements—and they know what they're talking about.

"We realize this is often extremely difficult," says Sophie Van S. Theis, executive secretary of an Eastern adoption agency, "because of people's suspicion of 'institutional' aid. Both parties prefer the doctor's personal touch to what they fear will be the cold, impersonal atmosphere of a public institution. The unmarried mother believes she will be censured for her misstep, and she and the foster parents are afraid of notoriety, red tape, and long delays."

Actually, though, most adoption agencies are anything but cold and impersonal. If their proceedings seem slow and ponderous, it's well to remember one fact: No amount of precaution can be too much when the future of several human beings is at stake.

The agencies do everything possible to protect the child, his natural

parents, and the adoptive family. As everyone knows, not all children for adoption come from unmarried mothers, but many do. And in such cases, the mother's decision to give up her baby is never accepted immediately, since it's often possible that she has been unduly and thoughtlessly eager to blot out the stain of illegitimate pregnancy. She is thus given time to think the problem through.

Then, too, the backgrounds of all concerned are minutely examined. The agencies want to assure the future legal, economical, and emotional security of the child by matching it with the right kind of parents.

There are usually many applicants for each available child. Obviously, then, an agency can do far better "matching-up" job than a physician who knows of one possible foster family. And, in the case of illegitimate children, the agency makes every effort to investigate the child's father—often a difficult and delicate undertaking.

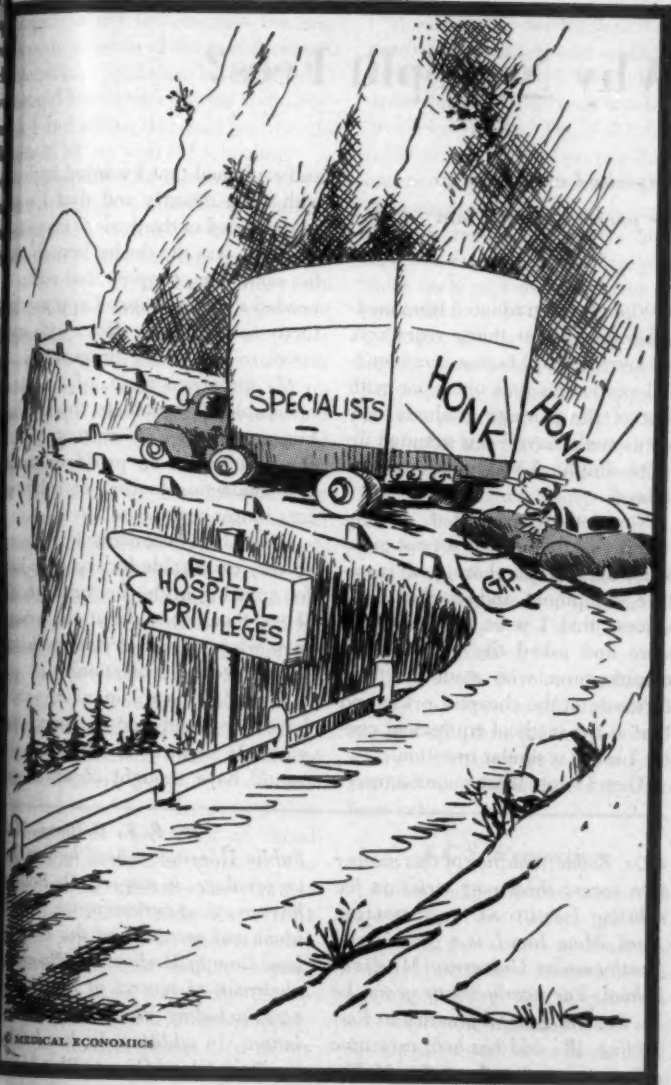
What, then, is the score? Should you ever take a hand in adoption beyond giving medical help and advice? Says Dr. Kosmak: "It is much better for the doctor to whom the baby's mother has turned for aid and comfort to recognize that more than medical knowledge is now involved, that it is much wiser for him, and less drain upon his time and energy, to refer the problem to those who are experts in adoption as he is in his field."

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Why Not Split Fees?

A spirited challenge to the present ethical ban

● When I was graduated from medical school about thirty years ago, my knowledge of business and medical economics was on a par with that of the average graduate. My status could have been summed up quite simply: I was broke and indebted.

Now let's suppose that, starting in practice then, I had set out to do some shrewd purchasing of furniture, equipment, and supplies. Let's assume that I went to a furniture store and asked the name of the manufacturer who made the best furniture at the cheapest price, and that at the medical equipment center I asked a similar question.

Then I wrote those manufacturers

and explained that I wanted to deal with them *directly* and that I was more in need of the dealer's commission than was the dealer himself. In the same way, suppose that when I needed some insurance I applied directly to the home offices with my novel, money-saving proposition.

My intentions were, of course, honorable: I wanted to thwart the business practice of "cutting in" the middleman on profits—a practice analogous to that of splitting fees in my profession.

Was I, in my economic innocence, so very censurable for trying to lick fee splitting in the business world? If so, then what about the young men who are now trying to lick it in the medical profession?

I need not explain what would have happened had I played this game. It's obvious what people would have thought of anyone so

**Dr. Bollaert, author of this answer to a recent three-part series on fee splitting [MEDICAL ECONOMICS, April, May, June], is a graduate of Northwestern University Medical School. For nearly thirty years, he has been in general practice in East Moline, Ill., and has held executive offices on the staff of the Moline*

By F. E. Bollaert, M.D.
Public Hospital, where he has major privileges in surgery. Dr. Bollaert has served, at various times, as president and secretary of the Rock Island County Medical Society and as chairman of several of its committees, including ethics and public relations. In addition, he has headed the Rock Island County Blue Shield

naive as not to recognize the economic position of the middleman in American business. In one week I would have learned more about buying and selling than had been taught me in all my years of schooling.

Even after I'd been compelled to buy through a middleman, though, suppose I wanted to know *exactly* what I was spending my precious money for. From the furniture man I asked for an itemized statement showing how much of my dollar went to the manufacturer and how much to the salesman. From the instrument man and the insurance agent I requested the same type of statement.

About a week later I would have learned that these men had talked among themselves about this young doctor and had decided that as protection to the community he should be sent to a psychiatrist. To think that after all his years of schooling he had not learned the fundamentals of American business!

Now to get down to facts:

When, not long after completing my education, I joined a county medical society, I discovered that its members were a lot of "good foes" who worked in harmony. The only specialists in our society at that time were EENT men. Excellent surgery was done by general practitioners who had special training in surgery. And as general practitioners, they had a broad perspective on medical practice in all its phases.

It was routine for these G.P.-surgeons to accept referred work from their middleman confreres, with the understanding that fees would be divided equally. These old-timers realized that the referring doctor had not acquired an occasional surgical case by sitting on a plush seat; they also realized that every time a case was referred to them it helped them both professionally and economically.

Under this arrangement the referring doctor, the surgeon, and the patient were eminently happy. At no time since have I heard of a patient who has paid more to a surgeon because he has been referred. Nor have I known a surgeon to cut his fee because a patient came to him without referral. Nor have I ever heard of a patient who seemed especially interested in the financial arrangements the doctors had among themselves.

To forestall the inference that this article is written in self-defense, let me add that through the years only a very negligible part of my surgical practice has been referred to or from others.

A.C.S. Protection

About 1925 the American College of Surgeons became the self-appointed guardian of America's hospital activities. Essentially this was a noble move. But surgical control was overemphasized and the economic angle overdramatized. Theoretically, this was to protect

the patient. Actually, it protected only the surgeon.

A.C.S. leaders assumed that all the iniquities of practice found in their own hospitals must be present elsewhere. Although as a group they were vehemently opposed to centralization of power in government, they thought it would be wise to centralize control of medical economy in the A.C.S. central offices. Thus a minority group came to dictate the policies of the entire profession.

The clean-up campaign was launched: Patients must be protected; fee splitting must be stopped.

In 1928 all staff members of hospitals in my locale were required to sign a non-fee-splitting pact in order to keep those hospitals on the accredited list. This they did—including myself—because they could not foresee the eventual implications. Meanwhile, the old practice of fee splitting continued unchanged, and everyone was happy.

After World War II, however, things did change. We were bombarded by an influx of surgical specialists who had been thoroughly sold on the evils of fee splitting. The big-city masters had completely imbued them with the financial value of their skill, responsibility, and professional superiority. These young men (few of whom have any conception of general practice) now carry the masters' torch against that vile and debasing practice of fee splitting. And all in the name of

fairness and protection of the patient.

These men have had no experience with the life of a G.P. They haven't learned that a G.P. who works a forty-hour week (with about ten hours required for study, meetings, and so on) cannot make as comfortable a living as even his neighboring bricklayer unless he has some revenue from an occasional surgical case. They do not realize that no one brings patients to the doorstep of the G.P., and that to build a practice, he must, in fact, work like a dog.

Fairness to and protection of the patient? I wonder. Never until the advent of these young disciples did we hear so much public complaining about surgical fees.

Who suffers from the fee-splitting ban? The G.P. and the patient. Who gains? No one but the surgeon. As fee splitting has been curbed, surgical fees haven't dropped; they've skyrocketed.

Having addressed many gatherings on the subject of socialized medicine, I think I have a good idea of the public pulse. In question and answer periods I have *never once* been questioned about the matter of fee arrangements between doctors. But, oh, those surgical fees!

Here the entire profession is taken for a loop. Given only the barest opening, Mrs. Jones will speak a vehement piece about that operation her Johnny had last year. The bill she got for it has rankled ever

since. What it did to her savings account, she'll never forget. It's at the root of her belief that maybe socialized medicine would be a good thing after all.

Let me, by the way, assure my young surgical associates that, as individuals, I like every one of them. I admire their skill and training. I enjoy them socially. But when it comes to surgical fees and fee splitting, I think they've been pumped full of "boloney." I feel that they're unwittingly in the vanguard of those who are inviting Government control of medicine.

Already I can hear the cries of wrath: "But, Doctor, we have had special training. We are members of the sacrosanct surgical specialty groups and boards. We are endowed with extra-special skills. We have unusual responsibilities."

To all this I say, "You are to be

admired, and you are entitled to remuneration. But *not* ten to twenty times more than your colleagues who are equally well trained in fields other than surgery."

Through hard work, through his general ability, through active participation in the social and civic affairs of his community, the G.P. has gained the confidence of the Jones family and has acquired a good general practice. He has responded to the Jones's night and emergency calls; he has done many little unremunerative things for them—things that the specialist has little understanding of.

On a cold night he is called to see Mr. Jones and diagnose a ruptured viscus. (I have always been taught, by the way, that correct diagnosis is one of the most important responsibilities of an operation. In a scientific utopia, [MORE ON PAGE 185]

Lady With a Lamp

● In the course of covering a story for my newspaper, I heard of this true incident, which occurred in a Temple (Tex.) hospital:

Tension reigned in the operating room. A woman's life hung in the balance as a surgeon and an obstetrician delivered her baby by Caesarean section.

Later, the danger past, the anesthetist asked, "What was it, a boy or a girl?"

"I don't know," replied the surgeon.

"Neither do I," said the obstetrician.

A student nurse standing near-by spoke up shyly: "Let me see the baby—I can tell."

—HELEN BULLOCK



Upper gastrointestinal series



Intravenous fluids and transfusions

G.P. Treats 97.7% of Patients in Full

Others can do likewise, cutting referrals to minimum, if they have adequate equipment and a capable staff, he claims

● It has often been stated that a well-trained family doctor can care for 85 per cent of his patients without referring them to specialists or hospitals.

David G. Miller Jr., a Kentucky G.P., says this is an understatement. "At least 90 per cent," he maintains, "not only *can* be treated by the general practitioner, but *should* be."

He supports this claim with evidence from his own experience, for he himself provides what he describes as "complete medical care for 97.7 per cent of my patients."

Last year, in collaboration with the University of Louisville School of Medicine, Dr. Miller made an exhaustive study of his records for 1950. In that year, he saw 2,389 different patients. He referred eighteen (0.7 per cent) to specialists, thirty-eight (1.6 per cent) to other specialists in hospitals. The remaining 2,333 (97.7 per cent) were treated by him in full.

How is it that he refers so few?

Well, for one thing, there's his geographical location. He pre-

By Roger Mowbray

ictured here are some of the many procedures that general practitioner
David G. Miller Jr. handles, without physician-assistants, in his office.



Lumbar punctures



Deliveries



**Cystoscopies and
retrograde pyelograms**

tices in Morgantown, a tiny community (pop.: 859) nestled in the hills of western Kentucky. The nearest hospital is twenty-six miles away. Most near-by specialists are located in Louisville or Nashville (Tenn.), each around 100 miles distant.

Then, too, his patients—mostly farmers and strip and slope miners (plus an occasional bootlegger)—aren't entirely sold on the need for modern medical care. Many are poor and unused to modern conveniences. Few homes in the area have either electricity or running water.

'But these are minor factors. The real reason Dr. Miller makes so few referrals is his firm conviction that the G.P. should furnish as complete medical care as possible.

How complete can such care be? Where should the G.P. draw the line? At a point much further along than is customary now, Miller says.

In his own practice, he handles many cases that most G.P.'s would refer. For example, he treats all compression fractures of the spine and nearly all skin cancers; he gives superficial X-ray therapy for pyogenic infections and skin diseases; he does cystoscopies, retrograde pyelograms, and gastro-intestinal work for screening purposes.

In deciding between cases he will handle himself and those he will refer, he uses a simple rule of thumb: "Can I provide the same sort of care that I'd want my wife or son to have?" When in doubt, he sends the patient to a specialist.

(And, of course, he automatically refers all abdominal and other major surgery.)

In Miller's opinion, any G.P. "with curiosity and the desire to really help people" can accomplish what he does. He has perhaps no more formal qualifications than the average G.P. With no regular residence training, he has had to rely largely on experience, "circuit-rider" post-graduate courses, and help from colleagues.

When he decided to do cystoscopies and retrograde pyelograms, for example, he prepared himself by taking a medical school post-graduate course. On its completion, he spent a number of afternoons in a urologist's office. Whenever he needs more information about a procedure, he doesn't hesitate to ask the advice of a specialist-friend.

Naturally, to handle a wide assortment of cases you need plenty of equipment. Miller's office fairly bristles with medical apparatus. As an example of the variety of cases he handles in his office, see the breakdown accompanying the floor plan on the facing page.

A set-up like this, it goes without saying, runs into money. Miller has about \$25,000 tied up in the building, another \$25,000 in equipment. His investment in equipment is about four times the average of that of other G.P.'s—and it would have been much higher if he hadn't done some improvising.

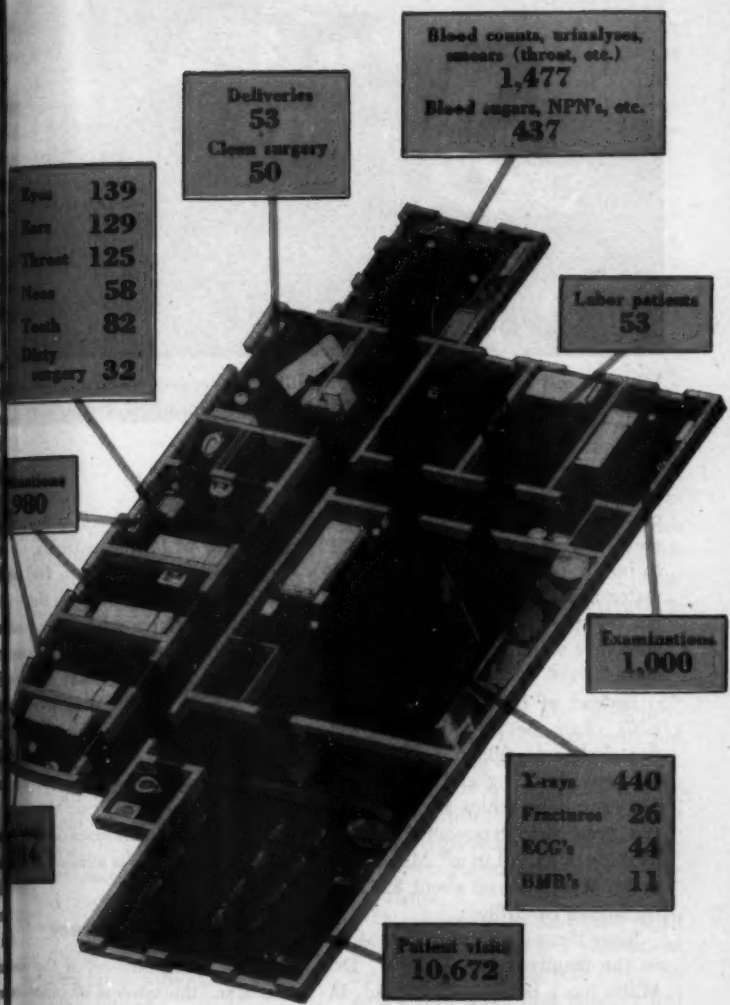
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In a recent year, 10,672 patient visits were made to Dr. Miller's office. Floor plan shows number and kind of procedures handled in each room.



Like the rest of his large office, Dr. Miller's reception room [A] exhibits neither frills nor fancy gadgets. His wife, an R.N., often assists him.

clave from Army surplus for \$45 and spent another \$50 converting it to bottle gas and hooking it to the water line. "It's not chromium and not very pretty," he says, "but a new autoclave would have cost me a lot more."

Instead of buying an expensive ENT chair, he picked up an old dental chair for \$25 and added \$75 for new plumbing and upholstery. His examining tables are mostly of the Army field type—some costing as little as \$5. All in all, Miller estimates that he saved about \$20,000 by buying carefully.

Since there is only one other M.D. in the county (pop. 11,300), Dr. Miller has a heavy patient load. In 1950, for example, he handled 10,672 office visits and made 566 house calls. His files bulge with the his-

tories (collected over a thirty-year span) of 12,696 patients.

Dr. Miller's office, staff, and routine are set up to cope with the ability to fifty patients who come to him during morning and afternoon office hours. His office has plenty of work space: five treatment rooms, an X-ray room, a labor room, a delivery and clean-surgery room, and a lab. His staff includes a receptionist, a secretary, a nurse's aide, a technician, and a housekeeper. His wife, an R.N., also is available when necessary.

E For Efficiency

When Miller arrives at the office at 9 A.M., the wheels of office routine are already turning smoothly. Basals and gastro-analyses, begun by the technician two hours earlier,



takes the patient's weight, checks blood pressure and urine, and asks questions about toxemia. If the ankles are the least bit swollen, she checks for edema. If anything is abnormal, she calls the doctor.

Now consider, as another example, a patient who comes in with a boil. If he's had several before, the nurse's aide takes his temperature and white count; if the boil suggests a carbuncle, she tests his urine for sugar. If the boil is ready to be opened, she places the proper tray beside the patient so that the doctor can go ahead as soon as he arrives.

To increase efficiency and avoid mistakes, the drugs and instruments needed for each procedure are recorded in a loose-leaf binder. Each lab procedure is similarly outlined. Thus the doctor can ask for a pneumothorax tray and know he'll get exactly what he wants.

'Cafeteria Style'

Does this sound like "assembly-line medicine"? Miller contends that there's nothing assembly-line about the *quality* of care, although he readily admits that the way in which service is given is "more or less cafeteria style rather than de luxe dining-room."

"I always try to find time to sit down and talk with a patient, or have one of our office staff do it," he says. "That way, most patients feel they get personalized care and are not being rushed through."

Miller's present set-up dates back

are out of the way. Four or five patients, admitted a half-hour earlier, are in treatment rooms awaiting his attention.

The nurse's aide and the receptionist have already found out what needs to be done and have completed routine procedures. On the doctor's desk are appropriate history cards, each with an attached slip giving the patient's name, complaint, and the number of the treatment room he's in.

Miller delegates a good many routine procedures to his assistants. His wife and the nurse's aide handle such things as immunizations and injections, often without the doctor's seeing the patient.

The nurse's aide, for example, does the regular OB checks following the initial examination. She

to 1946. A decade earlier, he had set up practice over a local drug-store with his wife as his only assistant. At that time, half the babies born in the county were being delivered by midwives. Many of the people considered the new, 28-year-old doctor too young to preside over a delivery.

Rural Obstetrics

Mrs. Miller laughs when she recalls one of the first OB cases that she and her husband were called out on: They had decided to move the patient closer to a bedroom window, for better light. As Mrs. Miller started around the bed, she fell through the floor into a two-foot-deep trench. The patient's explanation: "That's where we go when we don't want to go outside."

As time went on, Dr. Miller managed to get most of his OB cases into one of two small hospitals, twenty-six and thirty-two miles, respectively, from his office. But patients and their families objected to the expense and to having the mother out of the home.

He was already delivering an occasional baby in his office, since every so often a woman would be so far advanced in labor when she came to see him that there would be no time to spare. A few such incidents finally gave the Millers the idea of doing office deliveries regularly.

As it has turned out, this is as convenient for doctor as for patient.

Miller can keep his eye on the woman in labor and still not neglect his other patients. Usually mother and child are on their way home by ambulance about two hours after the delivery. Those who stay overnight are charged neither room nor board. Relatives supply any necessary meals.

Dr. Miller thinks twice before sending any patient of his to a hospital. He contends that physicians in general rely too much on hospital physical facilities. As a result, the patient pays a bigger medical bill and loses time. Miller's remedy: more diagnostic work-ups and treatment in the doctor's own office.

Statistics Support Him

Dr. Miller believes the proof of his theories lies in his own practice. He likes, for instance, to compare 1950 death rates in Butler County, where he practices, with those in Jefferson County, which includes the city of Louisville with its specialists, hospitals, and medical school. Butler had 9.0 deaths per 1,000 people as compared with 10.6 per 1,000 in Jefferson. Butler had 0.9 deaths per 1,000 under a year old, as compared with 0.84 in Jefferson.

Dr. Miller's practice seems to have heightened his professional stature. He is on the teaching staff of two medical schools—as professional lecturer in medicine at the University of Louisville, and as as-

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stant professor of preventive medicine at Nashville's Meharry.

Specialists in Louisville and Nashville, he says, have enough confidence in him to accept his work-ups (although at first they didn't). He can now send a patient to the city for surgery Sunday night, and the specialist will operate on Monday morning.

Although many specialists, and perhaps some G.P.'s, may think Miller goes too far in trying to provide complete medical care, his col-

leagues in the American Academy of General Practice have high praise for his work. As Dr. Carroll Andrews of Sonoma, Calif., says: "He's a real missionary. He's done the things that we were told in medical school couldn't be done."

Adds U. R. Bryner of Salt Lake City, A.A.G.P. president-elect: "Miller is doing as high-class a job of practicing medicine as can be done in big-city hospitals. He's a shining example of what a country doctor can do."

END



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"I've been waiting so long that I'm beginning to feel better."

Our 'Free-for-All' V.A. Hospitals

At institutions like the one described here, more and more free medical care is being given the able-to-pay veteran with a non-service-connected ailment

30. ARE YOU FINANCIALLY ABLE TO PAY NECESSARY EXPENSES OF HOSPITAL OR DOMICILIARY CARE?

☐ YES

☐ NO

● On March 20, 1951, Francesco Mannarino was admitted as the first patient of the new \$5.8 million Veterans Administration hospital in Erie, Pa.

Much clapping of hands by the local press and radio greeted this event; but considerably less enthusiasm was displayed by Erie's 200-odd physicians. It's not that they didn't favor better medical care for local war-wounded. They just weren't convinced that the hospital had been built for that purpose alone. Their skepticism, like that of their colleagues the country over, was based on this disturbing fact:

Two-thirds of the 108,000 patients in V.A. hospitals today are getting free treatment for non-serv-

ice-connected ailments. Yet the V.A. keeps building toward an empire of 174 hospitals—the top figure presently authorized.

Why are veterans with non-service-connected illnesses flooding V.A. hospitals? Because most of them are chronic and long-term cases who can't afford private care, say veterans' organizations. If the V.A. didn't care for them, it's claimed, some other public agency would have to.

A good many medical men are inclined to agree with this reasoning when applied to TB and neuropsychiatric cases, which account for about 65 per cent of the V.A. load. But what about the other 35 per cent? Couldn't many of these pay for their own care?

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LARY CARE

t the V. A. Nationally, the picture is obscured
empire by a cloud of high-level claims and
ure pro counterclaims. The best way to
sharpen the image is to narrow the
non-ser focus. How does the problem look,
ding V.A. for example, in Erie, now that the
them an city's V.A. hospital has passed its
ases wh first birthday? Has the skepticism of
ay veter local doctors been justified?
A. didn't The Erie Veterans Hospital,
ed, some which serves the city of Erie (pop.
have to 130,000) and surrounding north-
men an west Pennsylvania, is one of ninety-
reasoning nine general medical and surgical
neuropsy hospitals operated by the V.A. Since
ount fo it doesn't, as yet, admit neuropsychi-
A. load tric or TB patients, its non-service-
35 pe connected case load is confined to
ese pe the 35 per cent group mentioned
above.

Question 30 [◀] on V.A. hospital application forms is the open-sesame for veterans with non-service-connected disorders. All they do is check "NO," and they're admitted without further investigation. In Erie, Pa., V.A. hospital [▲], only 15 per cent of cases are service-connected.

From July to December, 1951, the hospital admitted 548 patients. Of these, only 15 per cent were treated for service-connected disorders. The remaining 85 per cent had non-service-connected ailments.

How many of this latter group could have paid for private hospitalization? Probably a good proportion of them.

To get into the hospital, the veteran must fill out an application form. Buried in small type is this question:

"Are you financially able to pay necessary expenses of hospital or domiciliary care?"

On the back of the form is a para-

By Roger Menges

graph pointing out the penalty for false statements. But this warning is strictly academic. A law passed by Congress in 1934 states that the veteran's word is sufficient evidence of his financial need. "We are not in a position to question the statement of a veteran," says Dr. Harrison S. Collisi, manager of the Erie Veterans Hospital. "All we're concerned with is his medical and legal eligibility."

Eyewitness Accounts

Erie doctors, however, are concerned with the veteran's financial means. And you don't have to talk to many of them to elicit comments like these:

¶ "One of my patients, an engine watcher for the New York Central Railroad, needed hospitalization for a condition in no way connected with his war service. He had New York Central mutual benefit insurance and other policies that paid direct indemnity for illness. These policies wouldn't have covered his entire billing, but I was sure he'd have no trouble making up the difference. So I suggested that he go to St. Vincent's Hospital. The next thing I knew, he was up at the V.A."

¶ "A long-time patient of mine, a World War I veteran of substantial means, had to have an operation. When I suggested a local hospital, he told me he preferred the V.A. hospital. I pointed out that he could afford private care. 'Sure. I know,' he answered, 'but there's no use pay-

ing for what you can get for nothing.'"

¶ "A punch press operator came to me with a hernia that had developed after he got out of service. With his insurance, an operation in one of our private hospitals would have cost him about \$15 in out-of-pocket expenses. That man was earning around \$75 a week. But he still insisted on going to the V.A. hospital."

The doctors say such free-loading is by no means limited to veterans in the low-salaried brackets. They point out that recent recipients of V.A. medical care in Erie have included (1) "a leading State Street merchant who could buy and sell most any of us," (2) one of the city's councilmen, and (3) a local veterinarian.

Although the V.A. hospital's records tell nothing about the financial status of patients, they do indicate that about one out of five carries voluntary health insurance. (In addition, an undisclosed number have accident and health policies that pay the individual directly.)

Insurance for What?

How much of the cost of private hospitalization would such insurance cover? There are no exact figures, but a sampling of a few cases in Erie reveals that insurance would have paid on the average, 75 per cent of the total bill, leaving an average out-of-pocket cost to the veteran of about \$170. The bills in these cases ranged from \$300 to \$1,200.

noth
Actualy, insurance *could* pay for
an even *greater* percentage of the
cost of private hospitalization. For,
Erie doctors point out, V.A. care
is more expensive than private care,
for two reasons: (1) The average
stay in the Erie V.A. hospital (about
twenty-nine days) is much longer
than in local private hospitals (un-
der ten days); and (2) V.A. care is
much more lavish.

"Nothing is done to hurry the
veteran in Erie," says a V.A. consult-
ant. "Nothing is spared. They'll
make X-rays and lab tests till hell
freezes over."

When the veteran carries volun-
tary health insurance, the Erie V.A.
hospital attempts to collect from the
insurers. But some companies refuse
to pay, and the V.A. is reluctant to
sue, since its right to collect is based
upon an administrative interpreta-
tion rather than a specific law. Be-
sides that, a number of companies
have policies with clauses that ex-
clude benefits for hospitalization in
non-supported institutions. In cases
like these, the taxpayer is stuck.

Roughly a third of the working
people of Erie are employed by Gen-
eral Electric. The company spon-
sors an insurance plan for most of its
13,500 employees that provides (1)
up to \$175 for surgical operations;
(2) up to \$10 a day, to a \$700 max-
imum, for hospitalization; (3) up to
\$100 for special hospital services. It
also pays the disabled employe
from \$22.50 to \$35 a week, up to
twenty-six weeks.

A good cushion against the costs
of medical care? It would seem so.
Yet a large number of the patients
admitted to the Erie V.A. hospital
are General Electric employes.

Of course, the \$64 question is
simply this: What does the V.A.
mean when it asks, "Are you finan-
cially able to pay necessary expenses
of hospitalization?"

It means, says one Erie doctor,
"that you can have a well-paying
job, and that you can afford to buy
such 'necessities' as a Studebaker
convertible and a television set. But
if your medical care imposes the
slightest financial strain, then you'd
better run to the V.A. and get it
free."

Many doctors blame local veter-
ans' organizations and their service
officers for this interpretation. But
the service officers, who advise vet-



erans, are indignant at such an accusation. They're likely to retort that the physician who complains about hospitalization of non-service-connected cases can't have much of a practice of his own.

Who, in the opinion of veterans' groups, cannot afford private care? "Most veterans can't," says a spokesman for one organization. "The majority are wage-earners and have families, and they should be entitled to V.A. hospital care. Unless a man is making \$4,000 or better a year, he simply cannot afford to go to a private institution."

But veterans' advisers point out that it's hard to tell in advance just who can meet private hospital bills. The length of treatment is often unpredictable, they say, and unforeseen complications may develop. Thus a prolonged hospitalization at private rates might bankrupt anyone, they argue.

Free hospitalization is defended by the service officer of one organization as "a meager return" for what the veteran has suffered: "After all, the veteran was out there in combat stopping bullets while the civilian was coining money in a defense plant."

M.D.'s on Carpet

If anyone's to blame for the abuse of V.A. facilities, it may be the doctor himself, charges a high-placed official of the American Legion.

"Who fills out the medical part of the application form?" he asks.

"The local doctor. [So] doctors themselves control to a great extent who shall be patients."

"Oh, come now," answers an Erie physician. "All I do is write the history, symptoms, lab findings, and diagnosis. Suppose I refuse to do this? The veteran simply takes the form to another private doctor or to one of the men at the V.A. hospital. By refusing, I would simply be antagonizing a patient."


Some Erie doctors claim that they do their best to talk the veteran into going to a private hospital if he cannot afford it. But they report little success.

Besides the ability-to-pay issue, Erie doctors gripe about the V.A. hospital's waste and red tape. One M.D., for example, was supposed to give follow-up treatment to a veteran who'd been released from the hospital. "It was six weeks before I got the case summary," he says. "The boys up there are past masters at one thing, believe me, and that's taking their time."

"It's the old Army game all over again," says a V.A. consultant. "Why, you've almost got to fill out a directive to close the door behind you."

"They've got two to a half-dozen of every kind of equipment, whether it's needed or not. But they manage to use it. If you stub your toe and go there for treatment, they're as likely as not to take a chest X-ray."

"None of the doctors here has been hurt ap- [MORE ON PAGE 18]



Administrative Medicine: Make It a Specialty!

*Do it today, says this physician, or you'll be
knuckling down to full lay control tomorrow*

• Most doctors deplore lay control of medicine; yet many of those same doctors are actually furthering it.

How?

By permitting laymen to get an increasingly secure grip on a vital branch of the professional family tree.

Ever since medical care left the stage when a little black bag was a complete health center, there has been a need for persons skilled in administrative medicine. That need has been most acute not in Government installations (which usually use physicians), but in such civilian agencies as hospitals, clinics, health insurance plans, school systems, etc.

Should top administrators in these

fields be physicians or laymen? Laymen have already carved out a comfortable niche in this new profession. And many physicians seem determined to make them even more comfortable.

Even the terminology is rigged against the doctor. The ordinary phrase is "medical administration," which sounds like a kind of administration. In fact, however, it's really "administrative medicine," which is obviously a branch of medicine. A layman could no more practice *administrative medicine* than *internal medicine*. But anyone from the foreman of a chain gang to a 5-&-10 manager can practice administration.

So let's begin, at least, by call-

By Barton Lawden, M.D.

**As a physician-administrator who holds an important post in a government agency (and was formerly with a large medical association), the writer prefers to use a pen name. His views do not necessarily reflect those of MEDICAL ECONOMICS; but the editors gladly give space to what they regard as a stimulating exposition of one side of a growing, controversial issue.*

ing administrative medicine by its right name.

Administrative medicine combines medical administration with certain special professional functions. The physician in an administrative post has all the duties of a lay official, and then some. He must cope with such problems as financing, personnel, repairs, statistics, maintenance, public relations, purchasing, office management, etc. But administrative medicine may also include these duties, which only a doctor can (or should) carry out:

¶ Appraising the efficiency of a medical staff;

¶ Approving the purchase of surgical or medical equipment;

¶ Determining the admissibility of a patient;

¶ Approving the discharge of a patient or the discontinuance of a line of treatment;

¶ Determining appropriate fees for doctors in health insurance programs;

¶ Regulating the frequency of visits or other medical services in various out-patient and medical insurance agencies;

¶ Hearing and judging grievances concerning alleged misconduct of, or incompetency of, physicians;

¶ Recruiting and assigning physicians;

¶ Assuming legal responsibility for medical decisions;

¶ Approving—or not approving—relatively untried medical or surgical procedures;

¶ Making decisions on various quasi-medical procedures (ventilation, food, architectural changes, etc.) that have an effect on patient care.

Thus, administrative medicine has a body of knowledge. It requires specialized skills. It can be taught and learned. Its practitioners grow through experience. Any book on medical history will reveal a star-studded roster of eminent physicians whose primary passports to fame were contributions to this field.

In short, it's a bona fide specialty, and it should be recognized as such. It lends itself well, for instance, to the organization of a board of examiners. Experience and training requirements can be readily formulated and objectively measured. If such a board limited itself to M.D.'s there would soon accrue a nucleus of doctors with unimpeachable status in the new specialty. After a decade or so, it would be a rare layman who could compete with physicians for key administrative assignments.

Now come the big "buts":

Will administrative salaries attract good physicians? Is desk work a waste of medical training? Why can't laymen continue to handle purely administrative functions? There's an answer to every one of those questions.

Take salaries, for example: The biggest earned incomes today go to top business administrators. The private physician's gross income may sound upper-crust; but his net in-

...n various come puts him many notches below
(ventilator) a big-company executive. Most re-
changes cent figures—for 1949—show an
n patients average net income among general
practitioners of only about \$9,000.
medicine And general practitioners are the
t requires primary source of physician-admin-
be taught istrators.

ers grow Does the chief executive of a large
book on hospital, a large health insurance
al a stu plan, a large health department, or
nt physi medical agency earn more than
sports \$9,000? Nearly twice as much would
this field be closer to the average; and that's
specialty for a forty-hour week—with retire-
d as an ment plan thrown in! Remember,
tance, too, that physicians would generally
rd of a command higher salaries than lay-
raining men for comparable administrative
y forms work.

ured. li Next objection: It isn't right to
M.D.'s divert our meager supply of medi-
nuclear cal talent into "routine" desk work.
able sta Here lies one of the great hoaxes of
fter a de the century. Let's take a look at that
e layman hoax:

physicians All sorts of well-meaning people
gnments now buzz around the doctor, each
": anxious to relieve him of some of his
ries at "routine." The nurse wants to do the
desk work hypodermics (and lately the intra-
g? Why venous and blood pressures) so
to handle that the doctor can apply his talents
functions? to higher things. The dietitian—as a
y one of service to the poor overworked doc-
tor—spares him the chore of work-
ing out diets. A technician relieves
ple: The him of the onerous job of manipu-
ay go to lating equipment. Everyone is so
The pri helpful.

net in As a result, we've reached a stage

where most of the people working on patients are laymen. The one thing still reserved for the physician is legal liability for malpractice if something goes wrong.

The medical administrator began—quietly and humbly—as a clerk. A doctor "headed" the hospital. But somebody decided that the M.D. should devote all his valuable time to the sacred calling of sitting at the bedside.

The clerk began to handle such details as ordering supplies and worrying about the heating equipment. As time went on, the senior clerk became a steward; then a superintendent; eventually an "executive director." Now when the doctor wants to order a ballistocardiograph or an oscillogram, he must satisfy his former clerk that it's a good investment for the institution.

Voluntary health insurance plans,



"Dinner is served."

many of them under medical society auspices, started out as amiable arrangements between doctors and patients for financing the cost of illness. A few clerks helped out in the office. Somewhere along the line, though, the doctor was shunted to the jejune dignity of a seat on a medical advisory board—and administrative control fell into the hands of the erstwhile clerks.

Laymen now write the publicity, handle promotion, calculate premiums, and set the fees. Fee setting, of course, is theoretically worked out with the medical advisory group. But how theoretically!

A lay administrator presents a graph showing that \$150 appendectomy fees will make the entire plan "actuarially unsound," whereas \$85 fees will keep it in the black. The medical advisers don't know enough about finance and administration to challenge the figures. They don't want to bankrupt the plan—so the lay administrator has the last word.

Medical practice today is becoming increasingly a corporate operation. If it isn't a large private practice group, it's a foundation, or a vast hospital out-patient department, or a labor union health service, or the V.A. home-town plan, or Blue Cross, or commercial insurance, or Blue Shield. More often than not, effective operational control rests in the hands of laymen. No matter how the operation is organized, though, some people need to be reminded that its reason for existence is to

give medical service to human beings. And that's the job of the doctor.

Ironically enough, the agencies most protective of the doctor's authority over medical procedures have been units of government. Despite repeated pressure, the Army, the Navy, the Public Health Service, and most state hospital systems have insisted that *physicians* retain control of their hospitals.

Since the induction of the present Chief Medical Director, the V.A. has appointed physicians to head nearly all its newly built hospitals. When the V.A. does not name an M.D. to manage a hospital, it's usually because the medical department can't find a physician sufficiently versed in administrative medicine.

Which takes us back to the point of this discussion: the need for trained physician-administrators. Why should doctors allow laymen to take over key functions just because laymen consider them "routine"?

The lay argument runs something like this: A doctor isn't equipped to select laundry equipment, floor wax, or cuts of steak. How can he know whether pillows should be stuffed with duck feathers or goose feathers?

This argument is confusing—and it's intended to confuse. Actually staff decisions of the sort mentioned are based on the recommendations of technicians anyway, whether the head man is a layman or a physician. (Does the average lay superintendent know [MORE ON PAGE 180]

Health Plan Rocked by Fee Frauds

**But it's cleaning house now,
and the end results may
benefit doctors everywhere**

• Jolted sharply by charges of dishonesty among its participating doctors, the California Physicians' Service is now in the throes of an intensive clean-up drive. To the extent that its efforts are successful, medical men all over the country will benefit.

Says John W. Cline, recent A.M.A. president: "The publicity has had a serious initial effect upon the medical profession and upon Blue Cross and Blue Shield plans . . . But I believe the net result will be good."

Here, in brief, is the story:

Revelations of wrongdoing in C.P.S. made headlines not only in California but throughout the nation early last spring. They started with the disclosure that some 200 doctors—mostly in the Los Angeles area—were cheating C.P.S. out of more than \$1 million a year.

The initial charge was made by Dr. Paul D. Foster, editor of the Bulletin of the Los Angeles County Medical Association, in an editorial entitled "Robbing Peter to Pay Paul." Pulling no punches, Dr. Fos-

ter called the activities of the 200 doctors outright "larceny."

The California Physicians' Service had in its possession sworn statements from patients and "photostatic copies of files and conclusive evidence which show the fraudulent tactics being used," Foster wrote. Most of the cheating, he said, fell into three major categories: overuse of the service, abuse of it, and outright fraud (which consisted mainly of billings for services never performed). It put one more obstacle in the way of honest physicians trying to give medical care on a prepaid, low-cost basis.

While the disclosures were greeted with horror and consternation, both C.P.S. and the California Medical Association promised swift, vigorous action. Less than three weeks after the story broke, C.P.S. filed the first of what it said would be a number of suits against doctors accused of wrongdoing.

The initial suit, a civil action filed in Los Angeles Municipal Court, was against a Long Beach physician whom C.P.S. charged with violation of his contract in making false

By Carl Dyster

***The author is science editor of the Los Angeles Mirror.**

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(CYCLOMETHYCAINE, LILLY)

claims for fictitious surgical services. The complaint asked specific recovery of \$332.40 and stated that C.P.S. believed about \$2,600 more was also due. The exact amount was not known, it added, because the doctor had refused to allow an audit of his books.

C.P.S. turned over to the Los Angeles County Medical Association at the same time two other cases in which there appeared to be evidence of fraud (the first doctor sued is not a member of the association). And it referred additional cases to its attorneys for action in the near future.

Meanwhile, a statement was issued by Dr. H. Gordon MacLean, then president of the California Medical Association, which sponsors C.P.S. Said Dr. MacLean:

"Other actions against other doctors no doubt will follow, since attorneys for the California Physicians' Service have been instructed to take any action deemed necessary at any time."

"Our legal action—harsh though it may be—is our guarantee to the public of our continuing belief in this and other types of voluntary health insurance."

Public Asks Questions

Action by the C.P.S. in routing out the few unscrupulous doctors in its membership has given Californians a yardstick for measuring organized medicine's sincerity. Doctors have insisted on their right to police their own profession; and the Cali-

fornia clean-up will serve as a demonstration of how effectively they can do so."

C.P.S. was set up in 1939 by the California Medical Association as an answer to proposals for a state medical-care system. Last year it paid out a total of more than \$18 million in benefits. In a politically volatile state, where social experiment is the rule rather than the exception, C.P.S. has won the admiration even of those who, with Governor Earl Warren, favor some form of state-supported medical-care program.

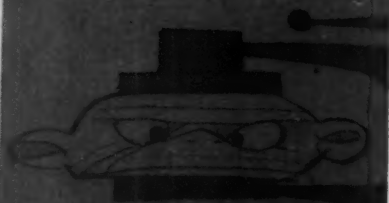
C.P.S. trustees regard it as particularly unfortunate, therefore, that revelations of irregularities on the part of some of its physician-members should have come at a time when the plan is bedeviled by numerous other difficulties.

Other C.P.S. Problems

Dr. Donald Cass, president of the C.P.S. board of trustees, reported in April that C.P.S. had lost more than 245,000 members since its peak in December, 1950, when 1,029,408 were on its subscriber rolls. This meant a drop of nearly 25 per cent in a little over a year.

Much of this was due to a split in Southern California between C.P.S. and the Blue Cross hospital plan. Until August, 1950, the two plans worked together. Now they are competing.

C.P.S. is also getting tough competition now from private insurance companies and from closed-panel



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work



worry



emotional disturbance

pressure, diet, work, worry,

emotional disturbances, visceroneurosis

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1. Hock, C. W.: J. Med. Assn. Ga. 40:22, 1951 •

2. Hufford, A. R.: J. Mich. St. Med. Soc. 49:1306,

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17:224, 1951 • 4. Pakula, S. F.: Postgrad. Med.

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then be reduced. *Note:* A high fluid
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throughout the day.



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plans (like Henry J. Kaiser's Permanente Foundation). And labor-management welfare plans have taken additional large numbers of subscribers from C.P.S.

There's another factor, too: A number of the 11,500 doctors serving C.P.S. have long been dissatisfied with it. They complain about the red tape and the low fees, which are undoubtedly responsible in part for the claim-padding.

Some of these doctors have already resigned. Now, in the wake of the scandal, more are threatening to pull out (though C.P.S. denies that any significant number have done so yet). A few doctors—fortunately, very few—even go so far as to argue that it might be best to close down C.P.S. and forget the whole thing.

Most of the California Medical Association's 11,000 members, of course, take a more considered view. They realize the tremendous stake private medicine has in the voluntary health insurance system and they're prepared to do whatever is necessary to treat its ills and to assure it a healthy future.

A special study committee, headed by Dr. Wilbur Bailey, president of the Los Angeles County Medical Association, is now giving C.P.S. a thorough going-over. It hinted recently that it might recommend, among other things, an abandonment, or at least a modification, of C.P.S. services in the home and office. Thus, while remaining a "serv-

ice" plan, C.P.S. would move toward provision of medical care in hospitals only.

Such a move would confirm the initial reservations a number of medical men had about extending health insurance plans—voluntary or not—to cover services performed outside hospitals. Home and office services, these men maintain, are "bad insurance," for they invite overuse and abuse.

How effective is the clean-up thus far?

As this is written, C.P.S. has one civil action pending in court, and restitution has been made in three other cases. At least two of the doctors involved in the latter three cases, it appears, will be ousted from the society; and if the State Board of Medical Examiners also takes disciplinary action, the licenses of the doctors may be suspended or revoked. No criminal actions have been brought by law enforcement agencies, although the state's Attorney General has asked for a review of the whole scandal.

Meanwhile, "the C.P.S. investigation is going on and will be continued as long as it appears necessary," says Dr. Lewis A. Alesen, current president of the California Medical Association.

But some medical men—among them Drs. Foster and Bailey—seem to feel that C.P.S. is not doing all it could and is not acting as swiftly and as vigorously as it should. Dr. Bailey, for instance, has criticized

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Provides gradual and sustained reduction of blood pressure with no dangerous, abrupt fall on oral administration.

Affords uniform rate of absorption and infrequent dosage adjustments.

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the service for not furnishing the medical associations concerned with more of its evidence on dishonest doctors, so that disciplinary action can be expedited.

"We can't go through C.P.S. books," he points out. "And until we get the evidence, there is nothing we in the medical associations can do."

Dr. Foster, for his part, insists that allowing offenders guilty of fraud to clear the slate by making financial restitution is "letting them off too easily." Like many others, he feels that only by taking appropriate action in the courts can C.P.S. convince the public of its determination to stamp out racketeering.

On the advice of its attorneys, the service has not given out the specific number of cases in which it believes restitution is due.

A total of \$4,240.02 has been recovered from the four cases acted upon to date, according to C.P.S. Some \$2,250 was recovered from one doctor, lesser amounts from the other three.

This seems to confirm what C.P.S. spokesmen have indicated unofficially—that the amount of money involved is far less than the \$1 million figure originally cited.

It cannot pass unnoticed that the four cases in which C.P.S. has taken action are a far cry from the 200 or more instances of cheating mentioned in the Foster editorial.

Chief reason for the absence of further court suits, C.P.S. explains,

is that many of the 200 doctors mentioned were guilty largely of overuse of the service rather than of actual fraud. While the doctors made unnecessary visits, referred patients to themselves, and performed X-ray and laboratory work not required, the C.P.S. board of trustees is frankly skittish about interfering with what the medical profession considers its prerogatives. The board prefers, it says, not to appear to dictate "proper" amounts of medical attention.

When the scandal first became public, C.P.S. had completed investigations on only three physicians against whom it had evidence that would stand up in court. Even when fraudulence is strongly suspected, it is often difficult to obtain "hard" legal evidence, spokesmen for the service point out.

In defending their decision to seek restitution as the first course of action, they maintain that C.P.S., with the help of the doctors, can clean its own house. And restitution, they add, does not grant offenders immunity from further action by law enforcement agencies, by the Board of Medical Examiners, or by professional conduct committees.

The present investigative procedure employed by C.P.S. has not been disclosed. But the questionnaire that helped expose the racketeering in the first place read, with minor variations, as follows:

"Dear Member:

"May we please have four min-



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Now available OBOCELL LIQUID . . .
a new palatable syrup for patients who prefer liquid medication.

Dose: Obozell is given three times daily one hour before meals (3 to 6 tablets daily

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... of your time . . . and your help?

"Like most companies, we periodically conduct independent audits. At this time, in reviewing thousands of records, claims are selected at random by the auditors to confirm certain items and to help authenticate our records.

"So . . . will you please help us, and our auditing firm, by briefly answering the following questions:

"1. Have you received medical care in the last six months?

"2. If so, who was your physician?

"3. What were the months during which you received care?

"4. Approximately how many visits were made each month?

"5. Please describe briefly, in your own words, the nature of your illness or accident.

"6. What type of treatment did you receive?"

This form letter was sent to patients who appeared to have top-heavy expense records with certain physicians. And it brought results.

In one instance, for example, it was found that a doctor had billed a patient for surgery and subsequent office calls in California while the patient had actually been in New York City.

Points of view among California doctors on the fee frauds scandal are mixed. Some believe that embarrassing situations like this are inevitable when physicians get involved in socio-economic problems they're not equipped to deal with.

Some say that in the interest of "good public relations," the story should have been hushed up. But most physicians, though understandably distressed, seem to spot a silver lining. Bringing this situation into the open, they say, will help preclude others like it—to the eventual benefit of the public and profession alike. ("With the publicizing of these evils," says a C.P.S. spokesman, "there will be, for example, fewer cases of improper billing.")

Effect on Subscribers

Reactions of C.P.S. subscribers seemed to center from the start on two main points:

1. What was C.P.S. going to do about the crooked doctors?

2. Would subscribers lose money because of the frauds?

Now most members appear to have accepted the explanation that since C.P.S. is a service-type health insurance plan, no patients have been "robbed." It's become apparent even to the lay public that the chief sufferers have been doctors themselves; the dishonest physicians have actually cheated *their colleagues*, by by taking more than their share from a common pool.

There has, consequently, been no wave of subscriber withdrawals because of the scandal, C.P.S. reports. Instead, a number of members have expressed their continuing loyalty and have offered friendly suggestions for handling the situation.

Perhaps the most important sin-

gle aspect of the episode—and one that observers feel was not lost upon the public—is that the initial disclosure of fraud came from the medical profession itself. It was undoubtedly a wise move for doctors to admit honestly that there was

some dirt in the house and to sweep it out into the open instead of tucking a rug. In the process, as some people view it, at least, they may actually have done more to *boost* their status with the public than to depress it.

Planning Your Vacation, Hmm?

Any doctor can plan, says this optimist. If, however, you really want to go . . .

• A vacation is something a doctor plans nine months ahead and postpones nine minutes before he's supposed to leave.

All legal advice to the contrary, the surest way to get a vacation is to fall suddenly and seriously ill in La Jolla while hurrying to make a house call in Hoboken. This accidental situation develops from a strange series of coincidences:

One day you just *happen* to put your hibiscus sport shirt, yachting cap, and open-toed sandals in a valise. Your wife wants you to drive her downtown on the way to your first house call. And the kids ask to go along for the ride.

You head for the center of town

when—wham! The road switches on you and you are pointed southwest. Somehow, this circumstance doesn't come to your attention until 3,000 miles later when the children suddenly remark that Hoboken was never like this. The shock of what happened causes you to collapse at a beach-side hotel.

All vacations other than this sure-fire one have a time of conception, a period of gestation, a moment of parturition—and a high percentage of stillbirths. Titillating yourself with talk about getting away from it all gets you nowhere if hospital appointments do not permit. As it works out, even months you're on at Hospital A, odd months at Hospital B. Hospital B is smaller than Hospital A, but Hospital B is the more important to you. On the other hand, Doctor C can cover you if

By Theodore Kamholz, M.D.



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Hospital B if that doesn't conflict with his own time at Hospital D. You must also consider your half-dozen expectant mothers, for whom your vacation is only D day plus or minus 7.

In the long run, you settle on a time that's poor for you, your wife, and your children, but reasonably convenient for the rest of the world. Yet this needn't discourage you; for whenever you go you'll find that it's the rainy season, or that the beaches are snowbound, or the pools are dry from drought.

Choosing the Place

The next problem is *where* to go. Actually, this not *your* problem at all; because no matter what place you name, your family will think up twenty good reasons for panning it. Either they've been there before and are sick of it, or they've never been there but they've heard it's awful. Anyway, the wrong people go there. Or there aren't enough of the right sex. The crowd is too young or too old. They do or they don't dress for dinner.

Since you were allowed the privilege of setting the *time*, the family demands the prerogative of setting the *place*. All this leaves you is the dubious pleasure of a smug smile when the complaints start rolling in midway through the vacation.

If—as is most unlikely—you should be stuck about where to go, the travel agencies are more than pleased to help you out. They shower you

with seductive folders and will plan complete vacations "at ridiculously low prices that you would never have dreamed possible." Of course, if you want a room with a *window*, there's an additional charge of twenty bucks a day. And if you'd care to make any of those interesting side trips to the interior of, to the top of, or through something, you double the amount.

Outfitting the Family

Clothing is no problem for the doctor either. But it holds the feminine contingent of the family enthralled. One school of thought suggests that the women buy their vacation clothes at regular intervals over the entire vacation-planning period, thus spreading joy to the chronological maximum. The hitch is that any garment bought more than a week before leaving is *old*; and for a vacation one must, of course, have something *new*. The other school encourages the little ladies to buy all their clothes in a last-minute orgy. Then if vacation plans must unexpectedly be canceled, the pain comes before the happy anesthesia has worn off.

Regardless of which school the girls belong to, it's safe to say that whatever clothes they buy will be wrong and too few; so the minute they arrive, the shopping spree begins all over again. This despite the baffling fact that of the ten assorted pieces of luggage you are carrying, *you* have unrestricted use of only

one-half of the smallest piece and must tote your razor and toothbrush in your pocket.

Who'll Cover For You?

Now consider who'll cover your practice for you while you're away: Of the five doctors who might do so, Doctor A hasn't got privileges in your hospital, you don't like Doctor B, you can't trust Doctor C, and Doctor D is already covering for Doctor E.

Doctor A *could* make your house calls except that he's 75 and doesn't like to make house calls any more. Doctor C won't think of covering your practice anyway, since he was mortally offended when you let Doctor B cover it two years ago. Doctor B won't walk on the same side of the street with you because a patient of yours married his nurse when he covered you last. Doctor D is leaving for the army midway during your vacation. And you can't ask Doctor E because he's your chief.

Actually, though, this is really no problem. You simply call Doctor F in a near-by state. *He's* glad to cover you, even though he lives sixty-three miles away, because you promise to cover for him in turn.

Gradually, in advance of your leaving, you have to prepare your patients for the fact that you will be away. You begin by talking vaguely about needing a rest. You underline it dramatically by holding several office hours unshaven. Pretty soon you narrow it down: "I need a rest be-

ginning a week from Thursday at 2:30 in the afternoon."

When your women patients object and weep because they cannot think of exposing their dietary indiscretions to a stranger, it's time to glance down shyly and say you're going to celebrate your twenty-fifth anniversary. In the women's league, this sentimental gambit never fails. After all, their own husbands never remember *how many years they've* been married.

As the hysteria at your imminent departure increases, you can even let fall the suggestion that it's really your *wife* who needs the rest. That does it!

The next items in planning your vacation are purely technical: You visit your lawyer, sign a bunch of papers, prepare your will, let him get your estate in order, and give him a nice fat fee.

You then call the plumber, carpenter, and electrician and have both home and office put in moth balls. Despite all these precautions, you can be sure that your sterilizer will be burned out before you return and that you will need a new refrigerator.

The last technical step is to borrow money on your life insurance, take out a second mortgage on your house, and wipe out your savings account. Now you're ready to go—or almost ready.

• • •

The time is M minutes minus 9—an interval just long enough for all

hell to break loose. The calamity that threatens you may be anything from double pneumonia in your youngster to having your rich uncle drop in from Alaska. It's during this critical period that preparedness is the watchword.

Luckily, you're not defenseless. Here are several things you can do:

Steal Away

First and foremost, rip out the telephone nine minutes before you leave. This spares you emergency hemorrhoidectomies, appeals from relatives for money to save the family factory, and warnings from radio-listening neighbors that the area you're heading into is one of epidemic pediculosis.

Don't answer doorbells. You then won't receive the telegram recalling you to active duty. You won't have

to suture the lacerated scalp of the boy next door. Nor will you be forced to make an exit diagnosing hepatoma of the liver.

Don't take in the morning mail. You then won't learn that you've been appointed this month's chairman of the Bubonic Plague Subcommittee of the State Hygiene Association. Nor will you see the raft of new bills that would make the whole vacation impossible.

Don't pick up the newspaper. You may read what happened to the stock market. Or you may spot headlines about a new world crisis that's guaranteed to make you feel like Nero fiddling while Rome burns.

In short, close the door. Lock it from the outside. Be deaf and blind even when a car and truck crash headlong on your corner.

You're off!

END

Love for Sale

● A psychiatric patient was regaling me with her many amorous adventures, sparing no details. In each case, it seemed, she had, after consummation of intimacies, remarked to her gentleman of the moment how nice it would be to have a new dress or a new item of furniture for her apartment; and in each case the gentleman had proved a gentleman.

As delicately as I could, I pointed out that this was simply a modified form of prostitution. As the import of my words sank in, my patient's anger mounted gradually but visibly. Finally it burst forth:

"What the hell do you expect me to do—give it away?"

—M.D., MICHIGAN



Color TV Goes to Medical School

Remember how the surgeon's back spoiled your view of the operation in your school days? Things are different now

● Thanks to color television, students at the University of Kansas Medical Center now get a surgeon's-eye picture of operations without developing eyestrain or jostling each other. Reason: Last fall, Kansas became the first medical school in the country to inaugurate a regular color-TV program for students. Since then, the idea has won the hearty approval of both students and faculty.

Under the Kansas set-up, as many as forty students can gather around a single receiver for a clear view of an operation. And color TV also has advantages over other instructional media, such as movies.

Says one student: "It's the difference between seeing the World Series in a newsreel and over TV. On television you don't know who's going to win." Faculty members, too, are less impressed, observe that the

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Camera in overhead mount [▼] transmits picture of operative site to television screens in auditorium. [◀] Classroom professor uses audio circuit to relay students' questions to operating surgeon, who wears hearing-aid-type receiver and throat microphone.

is nothing like an operation-in-progress for demonstrating how an experienced surgeon meets an emergency.

Nor is there much room for comparison between Kansas' present system and the black-and-white TV formerly in use at the school. It takes color to show students exactly how tissues appear in life.

Because color TV is expensive, other schools may think twice before jumping on the bandwagon. But Kansas officials feel that their system is well worth the \$35,000 it cost to install and the \$8,000 annual running expense. They point out that the set-up is used for post-graduate as well as undergraduate instruction. In time, they say, the program will also include non-surgical demonstrations.

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A.M.A. Splits Over Health Commission

Delegates finally patch up the rift by adopting a wait-and-see attitude toward the Magnuson group's report

● It was an advance press release from Washington that provided the spark. Medical leaders in Chicago first saw it on Sunday, the day before the A.M.A. House of Delegates convened. And as they read it, they began to burn. Said the release:

The average American doctor doesn't need a "\$100,000-a-year public relations firm to keep the American people from biting him in the leg," Dr. Paul B. Magnuson, Chairman of the President's Commission on the Health Needs of the Nation, declared Tuesday night . . . In an obvious reference to the American Medical Association's public relations firm of Whitaker and Baxter, which he has charged on a number of occasions with diehard opposition to the President's Commission, Dr. Magnuson said: "To attack it [the Commission] as a political device, to prejudice it and subject it to derogation before it has had a chance to function, is un-American and unfair . . ."

Ever since this commission was established,* A.M.A. officers had criticized the President's motives in setting it up. They had refrained, by and large, from criticizing the commission itself. But last month—apparently stirred by the press release quoted above—they cut loose a searing blast at the commission's chairman, its procedures, and its forthcoming end-of-the-year report.

What happened after that makes a unique case history in medical policy-making. For one thing, the A.M.A. delegates split down the middle on the first vote taken as to whether they should support their officers. For another thing, the subsequent debate was enlivened by possibly the sharpest face-to-face exchanges ever heard in A.M.A. circles.

And finally, the delegates—divided over the apparent choice of repudiating their leaders or repudiating the Magnuson Commission—were drawn together again by a skillfully-written reference committee

*The commission consists of fourteen private citizens (including five physicians) chosen by Dr. Magnuson and appointed by the President. Its assignment is to "make a critical study of our total health requirements . . . and recommend courses of action to meet these needs." Its deadline is Dec. 29, 1952.

By R. Cragin Lewis

Isn't safe, gradual, prolonged as



Nitranitol provides it . . .

permitting hypertensives to resume more normal lives

What's more, therapeutic dosages of NITRANITOL can be maintained over long periods of time . . . *without* frequent checkups . . . *without* worry about possible toxic effects.

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When vasodilation alone is indicated. *Nitranitol.* ($\frac{1}{2}$ gr. mannitol hexanitate.)

When sedation is desired. *Nitranitol with Phenobarbital.* ($\frac{1}{2}$ gr. phenobarbital combined with $\frac{1}{2}$ gr. mannitol hexanitate.)

For extra protection against hazards of capillary fragility. *Nitranitol with Phenobarbital and Rutin.* (Combines 20 mg. rutin with above formula.)

When the threat of cardiac failure exists. *Nitranitol with Phenobarbital and Theophylline.* ($\frac{1}{2}$ gr. mannitol hexanitate combined with $\frac{1}{2}$ gr. phenobarbital and 1 $\frac{1}{2}$ grs. theophylline.)

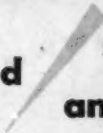
NEW . . . For refractory cases of hypertension. *Nitranitol P.V.* ($\frac{1}{2}$ gr. mannitol hexanitate combined with $\frac{1}{2}$ gr. phenobarbital and 1 mg. Veratrum viride alkaloidal fraction - biologically standardized for hypotensive activity.)

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aggravate each other.

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report that managed to avoid both extremes.

All this overshadowed nearly everything else that went on in Chicago last month. And because neither daily newspapers nor official journals could carry the full story, the following account may prove of special interest to the doctors back home:

Opening-Day Blast

The parade to the firing line was led by Dr. John W. Cline of San Francisco, the retiring A.M.A. president. Dr. Cline raked over the "politically inspired appointment of the President's Commission." There was convincing evidence, he said, that "it was created for the purpose of removing a very troublesome issue from public consideration during an election year."

This was familiar stuff to the delegates. Not so Dr. Cline's next three points, the third of which didn't appear in his prepared text:

1. The commission's procedure "is not compatible with fair presentation of the facts." Its digests of panel discussions "have the appearance of preconceived editorialized opinions of the person or persons preparing the abstracts."

2. The commission's report "may have all the misleading and dangerous attributes of a snap diagnosis ... probably will reflect the preconceived ideas of a majority of the commission."

3. The commission's chairman

"has directed bitter criticism at the American Medical Association, and we can no longer ignore that variety of attack. There seems to be [on the chairman's part] a planned assumption of omniscience in medical matters . . . Upon what meat does Caesar feed, that he has grown so great?"

The Furey Thrust

This brought the delegates up on the edge of their chairs. They stayed there, too, during a follow-up thrust delivered immediately thereafter by Dr. Warren W. Furey of Chicago. Acting with the advance knowledge and unofficial approval of the A.M.A. trustees, Dr. Furey introduced a hotly worded resolution enlarging on Dr. Cline's sentiments. What's more, he asked for immediate action on it.

The House of Delegates promptly resolved itself into a committee of the whole and pondered such "whereases" as these:

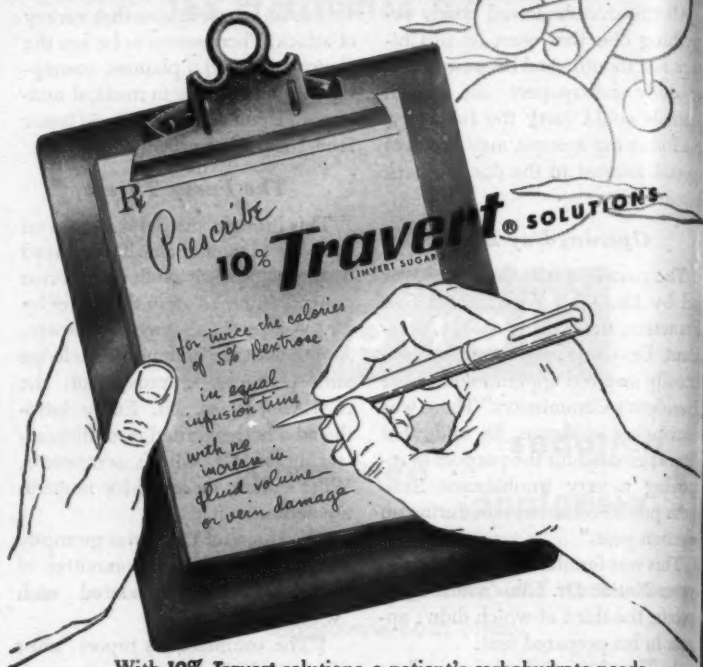
¶ The commission's report "must of necessity be a snap diagnosis which can only confuse and mislead the American people."

¶ Dr. Magnuson "has used his office repeatedly in recent weeks . . . for unfactual and bitter attacks on the medical profession."

¶ Dr. Magnuson "has become an unwitting captive of the forces of socialization, and is performing a damaging disservice both to his profession and to the medical welfare of the American people."

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maxed by the "resolveds." In these the delegates were asked to "publicly disapprove of Dr. Magnuson's unwarranted attacks on the leadership of American medicine" and to express their "complete lack of confidence in the Truman Commission headed by Dr. Magnuson, which is a politically-inspired agency of the Government."

Doctor to the Defense

At this point, the Furey resolution seemed about to be passed by acclamation. But a new voice called for the floor; and what Dr. Russel V. Lee had to say in the next twelve minutes made a lot of difference.

Dr. Lee, a group practitioner from Palo Alto, Calif., spoke both as an A.M.A. delegate and as a member of the Magnuson Commission. The Furey resolution, he said, "reflects intolerance and injustice . . . We have been warned about snap diagnosis; yet you are asked in this resolution to make a snap diagnosis. I urge you to adopt a judicial, scientific attitude toward the commission, and to reserve judgment on its final report. I assure you that this commission will serve no political purpose whatsoever; it will not help either party . . ."

As for the pointed remarks attributed to Dr. Magnuson, Dr. Lee said: "It is not a crime, to my mind, to criticize some of the activities of the A.M.A. Such criticism should not be curtailed. We must guard against tyranny within our own or-

ganizations as well as against tyranny in Government. We must guard the freedom of expression . . ."

When Dr. Lee finished, there was a moment of thoughtful silence. Then other delegates called for the floor, and the speaker recognized Dr. Robert L. Novy of Detroit. He moved that the Furey resolution be tabled—consigned to the shelf without further debate—and, almost immediately, it was. The vote: 85 delegates *for* tabling, 77 delegates *against*.

This narrow squeak was viewed as a sensation by the press. The delegates had been "split into warring factions," according to the Chicago Tribune. The tabling, said the New York Times, "was widely interpreted as an open repudiation by the policy-making body of the point of view of . . . the leadership of the association."

Actually, many delegates voted down the Furey resolution simply to gain time for discussion. They soon had their chance. It was introduced again that afternoon and sent to a reference committee. Next morning, when Chairman Walter E. Vest of Huntington, W. Va., opened the hearings, more than a hundred doctors were on hand for the show.

How Much Distortion?

First, the commission's procedures came up for review. Dr. Lee conceded that its digests of panel discussions, usually prepared by one of the participants, might be



"Time and attention," wrote William Heberden in 1768 of the syndrome he had named *angina pectoris*, "will undoubtedly discover more helps against this teizing and dangerous ailment."

Today, a variety of "helps" are used in the treatment of this "teizing and dangerous ailment." One of the more effective: 'Eskel', reported by Osher and Katz to be beneficial in 80% of cases.¹

in angina pectoris 'Eskel' the longest-acting coronary vasodilator

1. Read at the Royal College of Physicians, July 21, 1768.
2. New England J. Med. 244:315 (March 1) 1951.

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colored by the latter's point of view. But, he said, *all* participants were given a chance to correct such distortions before the final printing. And in any case, he added, the commissioners didn't depend on these digests alone; they got a vast flow of information through their own discussions, through staff reports, and through nightly browsing in the panel proceedings (3,000 pages, so far).

Would personal prejudices govern their final report? Not a bit of it, said Dr. Lee: "In meetings to date, this commission has demonstrated an exemplary lack of bias. I feel that its final report may well be a landmark in the history of American medicine—a notable document."

What about the "bite-in-the-leg" press release from the commission's office? That was bad, Dr. Lee admitted; it took a one-sentence excerpt from an otherwise "unobjectionable" speech prepared by Dr. Magnuson and blew it up out of all proportion.

Dr. Magnuson Speaks

At this point, Magnuson himself appeared at the back of the room. The chairman invited him to speak up in his own defense—and, with considerable bluntness, he did.

He started by recalling how, under his direction, the Veterans Administration medical department had been "pulled out of the muck." ("I didn't do it—you fellows did it.") It was in the same spirit of public

service, he said, that he took on the job of organizing the President's Commission.*

Medicine was certain to benefit from such a study, he declared—especially in its relation to the public. "I don't want to see an I.C.C. in medicine," he added. "The railroads got Government regulation when people became convinced they had a public-be-damned attitude. Let's not let that happen here."

He knew when he took the job, said Magnuson, that one year wasn't long enough for a completely comprehensive study; but "there has to be a start some place." His aim was to establish a sound pattern for the reviewing of health facts by a joint body of doctors and laymen. His hope was that "such a group will be continued beyond its original year, by Act of Congress or otherwise."

Who's a Dupe?

As for his being a dupe of Harry Truman, Dr. Magnuson offered these paraphrases of what he told the President to his face:

¶ "I think you have had some damn bad advice on this health issue."

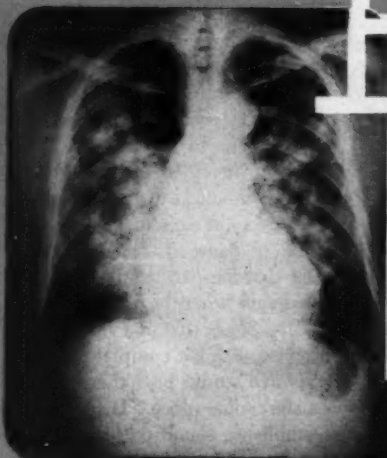
¶ "I will never in my life sign any report that will extend bureaucratic control one one-thousandth of an inch."

¶ "I have had no truck with Oscar Ewing, and I never would." [TURN→

*Both jobs required considerable financial sacrifice, Dr. Magnuson noted: "My income the first year I was in Washington amounted to one-fifth of what I'd paid the Government in income taxes the year before. You figure it out for yourselves."

H

armon



In congestive heart failure, passive congestion of the lungs is a typical finding, as well as edema in dependent tissue.

To "lighten the load" in Congestive Heart Failure

Calparate is particularly indicated. When edema is mild and renal function adequate... during "rest periods" digitalis and mercurials... when mercury is contraindicated or sensitivity to its oral use is present... for moderate, long-lasting diuresis in chronic cases.

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Calpurate conforms with the basic principles of modern cardiac therapy not only by relieving the heart load of excess fluids, but also by promoting increased cardiac output through myocardial stimulation. *Calpurate with Phenobarbital* is useful in relieving accompanying anxiety and tension, as in cases of hypertension.

Supplied as *Calpurate Tablets* of 500 mg. ($7\frac{1}{2}$ gr.) and *Powder*; also *Calpurate with Phenobarbital Tablets*, phenobarbital 16 mg. ($\frac{1}{4}$ gr.) per tablet.

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Calpurate therapy results in increased urine output, lowered body weight, and decreased edema.



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If you are thinking of investing in an x-ray machine the best advice you can get is that of your radiologist. He can tell you the type and make of machine that will best answer the requirements of your particular practice.

Why don't you ask him?



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His differences with the A.M.A., Magnuson attributed largely to politics. "The top hierarchy of the A.M.A. is political," he said. "It has to be, in any large organization such as this." As for Whitaker and Baxter, the A.M.A.'s public relations advisers: "They're at the bottom of this whole damn business, if you want my opinion, because they saw a fat fee flying out the window."

So saying, Paul Magnuson strode abruptly out of the room.

Hard to Explain

He was soon recalled, however, to explain his last remark. It proved rather difficult to do. "I am sure Whitaker and Baxter have done a

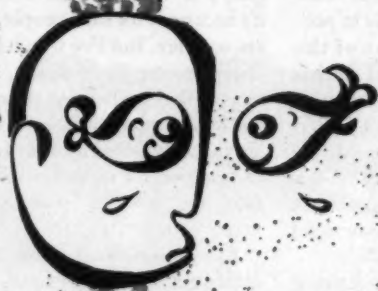
good job," he conceded. "Sometimes it's necessary for such people to fight fire with fire. But I've seen it happen elsewhere—in Government, for example—that we become prisoners of our public relations people. Doctors are busy men, and it's easy for them to lose control of policy-making. I think that may be what happened here."

Even this watered-down criticism didn't get by unchallenged. Speaking for the A.M.A. trustees, Dr. Walter B. Martin of Norfolk, Va., called it "completely contrary to the facts." No recommendation of Whitaker and Baxter, he said, had ever been followed without the unanimous approval of the Campaign Coordinat-



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"Can't see" weeds are flooding pollen into swollen eyes

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ing Committee. Rather than seeking to prolong the campaign, Whitaker and Baxter had sought to bow out a year ago. They'd been retained half-time for just twelve more months at the urging of A.M.A. delegates.*

The Vest Verdict

That wrapped up the reference committee hearings. For some eight hours thereafter, Dr. Vest and his committee wrestled with the wording of a report that might heal the split in medicine's ranks. Next day in the House of Delegates, it became clear they'd succeeded to a surprising degree.

Their report stated the reasons for believing that "the President's Commission was formed as a matter of political expediency"—there was no real argument on that. Then it moved on to more controversial topics and struck a delicate balance on each:

On the commission's procedure: "Your committee has received testimony from persons who have participated in panel discussions of the President's Commission and who subsequently have received abstracts of their remarks . . . The nature of these abstracts supports the impression that the thoughts the speakers intended to convey to the panel were colored and slanted in

the preliminary abstracts. [However,] your reference committee has neither the time nor the facilities for verifying this impression."

On the commission's report: "Despite such preliminary impressions, your committee believes that no judgment of the final report of the President's Commission which is to be made in December, 1952, should be undertaken until after its publication. Proper evaluation of that final report will require time and study before opinion from the American Medical Association can be given."

On the commission's chairman: "In his testimony before this committee, Dr. Magnuson stated that he undertook this task as a public service to his country, and that this action of his entailed considerable financial sacrifice . . . We commend the Board of Trustees for the restraint it has shown regarding some of the statements that have been attributed to Dr. Magnuson in the past. We believe that the board . . . has acted properly in pointing out certain inaccuracies and misstatements . . ."

On the performance of A.M.A. leaders: "The conduct of the officers and the Board of Trustees regarding the President's Commission is a reaffirmation of the principles subscribed to by the vast majority of the members of the American Medical Association."

This last sounded a bit like a whitewash. Taken as a whole, however, Dr. Vest's report was anything

*Of all those involved in last month's controversy, Whitaker and Baxter emerged with the greatest number of kudos. "They've been giving us nearly all their time, although paid on only a half-time basis," said Dr. Louis Bauer later in the session. "If it hadn't been for Whitaker and Baxter," he added, "we'd be operating under Oscar Ewing right now."

OTITIS EXTERNA*

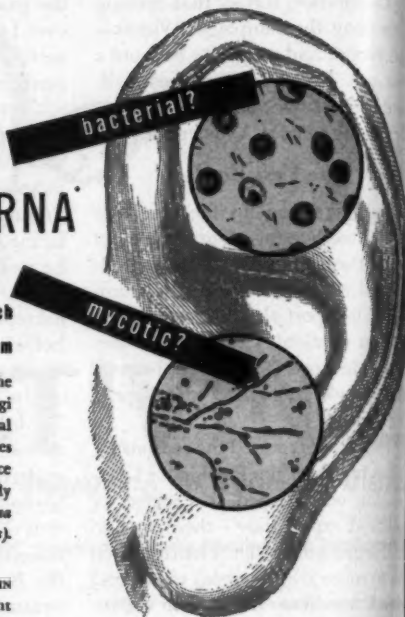
a new, two-way approach
to a stubborn problem

Opinion has been divided on the nature of common external otitis. Fungi were long regarded as the principal etiologic factor, but recent studies highlight the frequent presence of gram-negative bacilli... chiefly

Pseudomonas aeruginosa
(*B. pyocyaneus*).



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SAMPLES AND LITERATURE ON REQUEST

but. Of four main charges Dr. Cline had made against the President's Commission, the reference committee endorsed one, toned down two, and ignored one. Of five main points contained in the Furey resolution, the reference committee endorsed one, toned down one, and ignored three. The Vest verdict was, in fact, much more of a compromise than most delegates realized at the time.

Last-Minute Debate

Before they acted on it, there was a final flurry of debate. Dr. Lee urged that the Furey resolution be specifically declared "not passed." Dr. Cline raised the question of whether Dr. Magnuson shouldn't be disciplined. Dr. Louis H. Bauer of Hempstead, N.Y., put in the last word:

"This whole situation has been most unfortunate. There has been

too much emotion, not enough fact. I should like to see the bitterness taken out . . ."

Most of the bitterness *was* taken out a moment later, when, by an overwhelming vote, the delegates adopted the Vest reference committee report.

What did the delegates' decision amount to? In a nutshell, they agreed with their officers that the President's Commission was political in genesis; they agreed with the commissioners that its final report shouldn't be prejudged.

And they agreed—by implication, at least—that there can be no substitute for the democratic processes in medicine. As Louis Bauer, the new A.M.A. president, summed up the lesson learned: "Honest differences of opinion should be encouraged. They make the wheels of progress go around."

END

Language Specialist

● While on grand ward rounds, the chief attending got interested in the case of an Italian patient and tried to elicit a further history from him. Unfortunately the man couldn't speak a word of English. Finally someone remembered there was an interne elsewhere in the hospital who was reputed to have just the linguistic ability needed. So the chief sent for him posthaste.

The interne arrived and bustled importantly through the circle of doctors to act as interpreter. With the chief at his elbow, he approached the bedside. Then, in a loud voice, he shouted at the puzzled patient, "Hey, Joel Watsa mat?"

—MARVIN L. THOMPSON, M.D.



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little
acorns
grow"**

Many times the success of a particular therapy is largely influenced by seemingly "little" factors. Take soap in a dermatologic case, for example. During the past decade we have come to appreciate the importance of prescribing a mild, nonirritating soap as part and parcel of the therapy of most skin conditions to prevent further aggravation of the affected area and consequent retarding of recovery.

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A Green Light for Blue Shield

The Supreme Court vindicates doctors' plans by rebuffing

a Federal charge of 'monopoly'

• Doctors may now omit from their nightmare agenda the bogey of the Federal trust-buster swinging a bludgeon against Blue Shield plans.

In a recent ruling, the U.S. Supreme Court has squarely supported one such plan in its fight to survive a Federal suit. Moreover, for the first time, the Court has established broad legal limits within which doctors may sponsor prepaid medical care with no danger of anti-trust action.

Any other decision by the nation's highest tribunal would have had bitter consequences for medicine. For on the strength of the case of the United States of America v. the Oregon State Medical Society et al, the Justice Department had hoped to forge a technique for convicting other A.M.A. affiliates of conspiracies to restrain and monopolize prepaid medical care. F.B.I. men had allegedly ransacked the files of many medical societies in anticipation of a full-dress crusade.

Instead, the trust-busters ran into a stinging rebuff at the outset. Two

years ago, Oregon's U.S. District Judge Claude McCulloch found *not one* valid charge among the fourteen aimed at the medical men. So the Government appealed directly to the Supreme Court; and final defeat has now come: By a seven-to-one ruling, the Justices back up Judge McCulloch.

Among the far-reaching conclusions doctors may draw from the decision are these:

¶ With the test case blown to smithereens, further extensive anti-trust attacks on organized medicine definitely are *not* in prospect.

¶ In acknowledging certain principles of medical ethics, the Court has indicated that physicians' non-profit ventures in medical care are *not* to be judged by ordinary commercial standards.

All of which adds up to a really decisive victory for medicine.

In its implications, the case took note of organized medicine's complete reversal of attitude toward health insurance in the past two decades.

The choice of Oregon as a testing ground was dictated, apparently, by the fact of the violent struggle there in the late Thirties between organ-

By Don Cameron

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ized medicine and lay-sponsored prepay plans. Because Oregon medical societies in that period urged doctors to boycott the lay plans—and one society expelled several members for cooperating with such plans—the Justice Department assumed that the hostility must have carried beyond 1941. That year doctors organized Oregon Physicians Service as a non-profit corporation to furnish medical, surgical, and hospital care on a contract basis.

The Government's suit came in 1948, when Administration criticism of organized medicine was loudest. Named as defendants were the Oregon State Medical Society, Oregon Physicians Service, eight county medical societies, and eight officers of those organizations. The specific charges: They had conspired (a) to restrain and monopolize the business of providing prepaid medical care in Oregon; and (b) to restrain competition among prepay plans within the state.

The mass of evidence might almost have been assembled with some notion of impressing by sheer bulk. It reached the Supreme Court eventually in the form of a ten-volume, 8,000-page record, printed at a cost of some \$22,000.

The Government's case rested on four major contentions. Any of them, if substantiated, would have profoundly affected Blue Shield plans and doctor-hospital relationships everywhere. Their gist:

1. Oregon Physicians Service, in

making some payments across state lines, engaged in interstate commerce and so was subject to Federal jurisdiction and application of the Sherman Act.

2. In agreeing not to extend its coverage to areas where county medical societies were sponsoring their own plans, O.P.S. conspired with the societies to deprive these areas of competition.

3. Since the sponsors of O.P.S., by earlier hostile acts, had plainly indicated their desire to stamp out private prepay plans, it could be inferred that O.P.S. was merely a means to this end.

4. Doctors' talk of ethical objections to certain forms of contract practice was merely "camouflage to conceal their fundamentally economic concern."

Judge McCulloch made short



"I think I'm going to be mentioned in a will."



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work of these assumptions in a vigorous twenty-three-page opinion. So sharp were some passages that Government lawyers, in their appeal, complained that instead of considering the allegations on their merits, the Court had placed socialized medicine on trial—and found it guilty.

A sample of the McCulloch style: "Can it be that a profession . . . must remain a sitting duck while socialism overwhelms it? I would not expect any American court to hold that."

But Justice Robert Jackson, handing down the Supreme Court's ruling



"Got to humor the little woman, Doctor . . . Came in for a checkup."



"Can you make it home all right?"

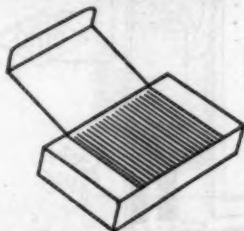
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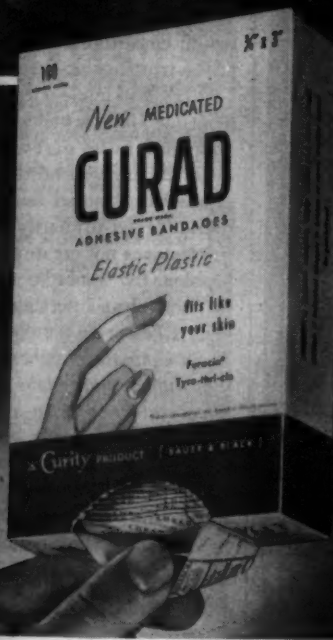
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ing, has found that the trial judge verbal flourishes "do not becloud the clear disposition of the main issues of the case, in all of which he ruled against the Government."

The Supreme Court has literally turned the trust-busters' four points inside out. As the court interprets these points, they stand not as an indictment, but as a defense, of the doctors' conduct of their prepay plans. In addition, they become a guide for future operations.

Here, step by step, is how the Government's "bad news" has been transmuted into good news:

1. *Physician-sponsored prepay plans do not become subject to Federal jurisdiction merely by making some payments across state lines.* This ruling, even if it stood alone, would constitute a substantial curb to the trust-busters' zeal.

O.P.S. had made out-of-state payments for Oregon policyholders who happened to be elsewhere when medical care was needed. The Supreme Court noted that a corporation engaged primarily in local activities does not create an interstate problem by "sporadic and incidental" acts of an interstate nature.

2. *Doctors do not conspire to restrain competition when they agree that their prepay plans will not duplicate coverage in areas where similar plans already operate.* Howard Hassard, legal counsel for Blue Shield Medical Care Plans, holds this point "of tremendous importance," since the Sherman Act expressly forbids any division of territories by competitors. The distinc-

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*Egg nog nutritive values from Bowes, A. de P., and Church, C. F.: Food Values of Portions Commonly Used, ed. 7, Philadelphia, College Offset Press, 1953.

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tion is that the Supreme Court does not regard separate Blue Shield plans as competitors.

Says Justice Jackson: "This is not a situation where suppliers of commercial commodities divide territories and make reciprocal agreements to exploit only the allotted market, thereby depriving allocated communities of competition." Whether the state-wide O.P.S. or a county association offers the coverage, local doctors must perform the services, Jackson points out; duplication would not cheapen or improve service "or have any beneficial effect on anybody." The Court therefore finds no trace of the unreasonable restraint alleged by the Government.

3. *Current intentions of organized medicine toward private prepay plans may not be inferred from hostility existing a dozen and more years ago.* From the huge mass of evidence, the Court excised "a great amount of archeology" dating from Oregon's earlier era of strife. It found "not the slightest reason to doubt the genuineness, good faith, or permanence of the changed attitude and strategy" of the doctors.

In plainer words, the Supreme Court has warned the Justice Department that past errors are not to be weighed against present practices.

4. *Medical ethics are a valid reason for removing a dispute from the realm of purely commercial considerations.* There are, affirms the Su-

preme Court, "ethical considerations where the historic direct relationship between patient and physician is involved . . . This Court has recognized that forms of competition usual in the business world may be demoralizing to the ethical standards of a profession."

The Court goes even further in sympathizing with the objections of Oregon physicians to forms of contract medicine in which an employer or insurance company becomes a third party in the doctor-patient relationship. It recognizes that in looking to an employer or insurance company rather than to the patient for his fee, the contract doctor "serves two masters with conflicting interests." It cites, in the evidence, cases where medical treatment was delayed pending company approval, and where a lay insurance



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In using this method of inducing infiltration anesthesia in over 600 cases of anorectal surgery for hemorrhoids, fistulas, fissures, perianal abscesses, pilonidal cysts and other lesions, no reactions have occurred and no pain was felt on insertion of the needle by any of the patients.

*Niemiro, B. J.: Proctology, 16:4 (Dec.) 1951.

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The Supreme Court's decision, like that of the trial court, may seem pretty much of a piece with the common-sense answers likely to occur to any thoughtful physician. In any rate, its rulings follow closely the arguments presented by the defense.

The encouraging fact is that the Supreme Court's thinking throughout has been *with* the doctor. It has done much to discredit the narrower view of the Justice Department.

However, the Court has added this warning: Its opinion is "without prejudice to future suit if practices in conduct of the Oregon Physicians Service or the county services, whether or not involved in the present action, shall threaten or constitute a violation of the anti-trust laws."

Blue Shield plans will still be vulnerable to the trust-buster, in other words, if, in the future, their actions become a restraint of trade or a monopolistic threat. There's a well-marked channel. But it's up to the skipper to keep on course.

Anecdotes

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*Kramer, P., and Ingelfinger, F. J., *Med. Clin. North Amer.*, 32:1227, 1948.

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Letters to a Doctor's Secretary

How an aide's routine eases examining room tension for patient, doctor—and herself

● Dear Mary:

I'm glad my last letter helped you, but apparently it still left something to be said. I understand and sympathize thoroughly with you when you say, "Assisting the doctor in the examining room is so strange to me that I don't feel sure of myself."

This is only natural. A business college graduate, while perfectly at home with the typewriter and the books, is bound to feel ill at ease at first in the surgery or examining room. Here you are no longer a secretary but a medical office assistant, and your relation to both patient and doctor is so intimate as to be almost embarrassing until you become accustomed to it. Yet I found, when I was with Dr. Barrie, that an aide must be able to interpret the doctor's wishes even more rapidly

and instinctively in the examining room than elsewhere.

Let me give you a few points that you can refer to until the routine becomes automatic. (If I repeat myself occasionally I'm sure you won't mind. It will serve as additional emphasis.)

I was fortunate in being taught by a registered nurse how to assist in an examination. I shall try to pass on to you what I learned from her. Let's discuss it in logical sequence.

1. Preparation of patient
2. Examination
3. Minor operations
4. Post-examination duties

Preparation of the patient begins early. When you draw from the files the case histories of all the people who have appointments for the day and lay them on the doctor's desk, they should correspond with the typewritten list you have placed on the blotter before him. Make a carbon copy of this list for yourself.

Open each record and read the last entry, so you'll know why the

* These letters were published originally as a series in *MEDICAL ECONOMICS*, signed with the nom de plume Myrna Chase. In response to many requests, they are now being

reprinted in revised and updated form. The complete current series, of which the present letter is the ninth, will also be made available in a portfolio.

By Anna Davis Hunt

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patient is coming and what the doctor is going to do. Make a notation after each name on the list, such as "breast dressing," "stitches out," "complete physical," "consultation."

If a patient is coming for the first time, the letters "N.P." can indicate "new patient." When office hours begin, you will then know at a glance what to do with the patients as they arrive; you will be able to distribute them to various rooms and to prepare the instruments needed in each case.

Now let's go through the complete preparation for examination of a new patient. (Lesser examinations and treatments will be based on this, and accordingly easy.) We'll take a woman patient, since Dr. Barrie examines the men by himself.

Helping the Patient

He rings for you and says, "Will you prepare Mrs. Newcomer for a complete examination?" You comply by ushering her into the examining room—as cordially as if you were inviting her into your own living room. Be cheerful and unhurried, as if she were the most interesting person in the world to you.

But don't waste time. Tell her specifically what part of her clothing she is to remove, then add, "I'll return in just a moment to get you ready for the doctor." Some such direct formula relieves the patient of both guesswork and the dread that the doctor may walk in before she is ready.

You can tell by looking at her how long to stay away: If she's young

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FOOD . . . PRE-COOKED OATMEAL CEREAL . . . PRE-COOKED BARLEY CEREAL

and streamlined, you need hardly turn around. If she's fat and heavily corseted, give her time.

A word here about arranging supplies in the examining room. Every doctor, naturally, has his preference as to where he wants his instruments kept. You will soon learn which ones Dr. Barrie wants constantly at hand and which can be put away in drawers for use as needed.

On top of the side table, within easy reach of the examining table, is the place for frequently used supplies like cotton balls, cotton-tipped applicators, and tongue blades. It's also helpful to have an enameled tray, covered by a paper towel, for soiled gloves and instruments. There is a cabinet for storing pillow slips, towels, large sheets for draping patients, and smaller ones for covering the table.

The important thing is to assign a definite place to each article and *keep it there*. Good housekeeping demands that both you and the doctor know immediately where to find what you need.

Preparing for Examination

Now let's go back to the patient. You find that she has disrobed, and you ask her to lie down on the table (which, of course, is covered with a clean sheet securely tucked in under the pad). After she has done so, you cover her with a fresh sheet and help her adjust her feet in the stirrups.

Standing at her feet, you then say,

"Now please push yourself down on the table toward me until your hips rest at the very edge." And see that she does it. Whether she says anything or not, she is embarrassed in this awkward position, and an assured, impersonal attitude will do more than words to help her keep her composure.

After seeing that her hips are in position, you move to her side and adjust the pillow—which she has probably left behind—under her head and shoulders. Ask her to keep her arms relaxed and at her sides. (Most women clasp their hands over their heads, thus causing the abdominal muscles to become too tense for satisfactory examination.)

Next you attend to the draping and adjustment of the covering sheet. If the patient has removed all her clothing, you carefully place a large towel over her breast under the cover sheet. The idea is that only the area being examined should be exposed at one time, and you can't be too careful about this.

There are fancy ways of draping the sheet over the patient's legs and securing it around the ankles. Dr. Barrie prefers simply to use a sheet that's wide enough to hang down on both sides and in front as far as the patient's toes. Then, when he starts the internal examination, he merely folds the sheet back across the top of the patient's knees.

Now that you have her ready, you quickly lay out on the clean glass table-top a pair of lightly powdered

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Otherwise the patient uses his own "available" nitrogen stores to accomplish the healing defect:

The patient "is better off before his nitrogen stores have been wasted than after. Surgeons have long noted that chronically debilitated patients are poor operative risks."³ Decubitus ulcers heal quickly in heavily protein-fed patients.⁴

These facts are clear, as is also the fact that Knox Gelatine, which is pure protein, offers a useful method of supplementing the ordinary dietary protein.

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gloves, a speculum that has been warmed under running hot water, a tube of lubricating jelly, dressing forceps, and a few cotton balls.

Then you summon the doctor.

Helping the Doctor

As Dr. Barrie makes the examination, you stand close by to hand him everything he needs. Since he likes to dictate his findings as he goes along, keep a small notebook and pencil in your uniform pocket.

I must mention here another little custom that may be unfamiliar to you. When the doctor wants you to hand him something, he'll probably just mention the article by name. He won't say, "Please hand me a tongue blade," or "I need a sponge now." He'll say, "Tongue blade," or "Sponge," and you'll hand it to him before the word has left his lips. (Arrange to watch him perform a major operation at the hospital some time, and you'll be thrilled by the greased-lightning efficiency with which this principle works. Most of the time he doesn't even ask. His assistant anticipates his need and places the required instrument in his hand.)

When you have been with him a bit longer, Dr. Barrie will expect you to take the patient's height, weight, pulse, temperature, and respiration. With a little practice you'll become expert at those duties.

For temperature-taking you give the thermometer a quick shake to force down the mercury, place the bulb end under the patient's tongue, see that she closes her lips on it firm-

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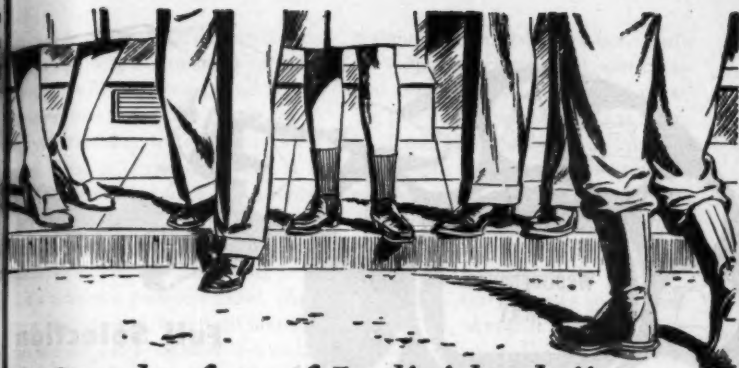
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...On the feet of Individuals."

Society advances on the feet of individuals. We Americans live under the highest standard ever achieved because we believe in and are permitted currently to practice three of the cardinal principles of progress—Invention, Research and COMPETITION.

Nineteen basic inventions influence our pattern of life today. Each one was created to satisfy a fundamental need. For example, the electric light industry has grown to an annual volume of \$501,500,000 in light bulbs alone; the value of aviation manufactures in 1951 in the United States alone was estimated at \$3,350,000,000 and in February, 1952, records show a \$2½ billion backlog of orders.

In every case, employment and sales volume grew enormously and the public enjoyed huge personal benefits.

Side by side with Invention came Research, exemplified by the competition of intelligent men questing for new materials, new methods, new processes, new scientific truths. Current advertisements tell of hundred-year tests to assure power materials for the future, technology that produces metals to withstand almost inconceivable heat, machines calculating 10,000 times faster than the mind of man, medicines that cure "incurable"

diseases, food processes that cook, sterilize and pack hundreds of cans a minute. And in every case, the public enjoys huge personal benefits.

This is what James A. Decker undoubtedly had in mind when he wrote the line, "Society advances on the feet of individuals." These "individuals" are you and I, all our countrymen, benefiting every day from Invention, Research—and COMPETITION.

Developing inventions, marketing products, and pursuing scientific research require substantial investments. A grave danger to their future now looms. In 1951, corporation net profits suffered a loss of 21% over the previous year. The reason—taxes too high, government controls and policies that interfere too greatly with private industry. If this continues, financial resources will dwindle, competition will be stifled.

Without free competition, American progress stops. No country can long exist when its government calls all the shots. We need competition to assure progress for people.

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ly, and leave it there three minutes, not permitting her to speak or move about. Remove, read, and record temperature; rinse the thermometer in cool running water, apply some soap, rinse it again, and stand it in a bottle of alcohol for a few minutes before finally rinsing, drying, and replacing it in its case. Normal temperature is 98.6° Fahrenheit.

To take the patient's pulse, place your first, second, and third fingers—the middle ones—against the radial artery just below the thumb, on her left wrist, pressing firmly. The normal pulse is about seventy-two a minute; count for half a minute by the second hand of your watch. Practice on your friends for a while. As you become experienced, you'll note volume and rhythm as well as rate.

The normal respiration rate is about sixteen a minute. You count by the visible rise and fall of the patient's chest wall.

Preparing for Operations

If, instead of examining a patient, Dr. Barrie plans to perform a minor operation—such as removing a wen or opening a carbuncle—your duties will be a little different. You will be expected to prepare a sterile tray and have it ready for him in the room where he will operate. The instruments to be used will depend upon the type of operation, so be careful to get detailed instructions from the doctor beforehand.

Since you have not had hospital

training and probably are not familiar with the principles of antisepsis and asepsis, get a handbook of nursing procedure, which explains them in detail. Such a book is Young's "Essentials of Nursing." Study it carefully as it relates to your work. And remember that anything that comes into direct contact with a wound must be sterile.

All the instruments to be used should be wrapped together in a towel and sterilized in the autoclave. (See the manufacturer's printed directions for operating this medical "pressure cooker.") When the package has been sterilized and cooled, you unfold it on the tray, using extreme care to touch only the outside of the towel. You can then arrange the various objects with sterile forceps.

You will also have autoclaved a package of two towels wrapped in muslin and a pair of powdered rubber gloves wrapped in muslin. These sterile packages are opened and laid on the table near the tray. Great care must be exercised not to touch or contaminate the contents. The sterile towels are to be placed around the operative area after it is prepared for surgery. It is a good idea to keep the above-described packets always on hand, sterilized, and ready for use in case of an emergency.

As Dr. Barrie proceeds with the operation, observe carefully what he does. He will appreciate your interest when you ask him later to explain



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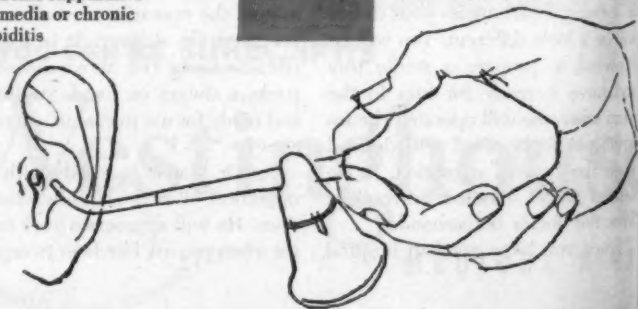
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anything you haven't understood. It won't be long before you are thinking right along with him, and are really able to assist him.

Cleaning Up

After the examination or the minor operation is ended, clean up as quickly as possible and get ready for the next patient. While the patient is dressing, strip the table, take the used linen under your arm, pick up the tray of soiled gloves and instruments (or, if just a few, take them in a paper towel), and depart for the surgery. There you drop the

linen into its container in the closet and turn your attention to a quick but thorough cleaning of the gloves and instruments.

Your electric water sterilizer is adequate for sterilizing everything used in the daily routine (excluding operative procedure). During office hours, keep this sterilizer half full of boiling water.

At the sink in the surgery you have a bowl containing melted soap and a long-handled, stiff brush. Grasp each instrument by its unsoiled handle, hold it under warm running water until it is thoroughly



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rimed, scrub it well with the soapy brush, rinse again, and pop it into the boiling water of the sterilizer. Rinse the brush and replace it in the bowl. Ten minutes is long enough for boiling metal instruments, but see that the water covers them completely.

Never boil any sharp instruments, such as knives or scissors, as it dulls them. Instead, after they've been scrubbed, leave them to soak in a strong antiseptic solution. Then, before leaving the office, remove them, rinse them in alcohol, and put them away.

Next the gloves. If you wish, you may lay them to soak in a pan of soap solution until you have time to scrub them clean with the soapy brush. Rinse three or four pairs at a time under running water, and place them in the sterilizer. Weight them to keep them covered with water while they boil for five minutes. Shake off the excess water and hang them up to dry. When thoroughly dry on both sides, powder the gloves by shaking them briskly in a tightly covered can containing about two tablespoons of cornstarch. (Talcum powder is no longer used, as it's considered an irritant.) Store the gloves in pairs, with the cuffs turned back about two inches.

The laboratory work that follows an examination in your office is not extensive. Only routine blood counts and urinalyses are done there. (Anything more complicated is referred to the pathological laboratory.) Dr.

Barrie's assistant, Dr. Carl, will train you in these simple procedures and in the preparation of specimens to be sent to the laboratory. Each specimen must be accompanied by a slip stating the patient's name and address, the doctor's name, what the specimen is, and the kind of examination desired. It is your duty to make out this slip correctly and to see that it accompanies the specimen.

Alertness Always

In the field of examining room technique you'll never go wrong if you're keenly interested in everything that happens.

The physical appearance of the room is the first thing to consider. It must always be spotless and orderly, with no unnecessary objects lying about—and never any dirty instruments, mussed linen, or other evidence of a previous examination.

As you unfold fresh linen for use, lay it aside instantly if it shows spots, tears, or mended places. You rent the linen from a linen supply company and it is part of the contract that they send only good, unspotted pieces. List and return the imperfect items to your delivery man, and check your bills carefully to see that you are not charged for them. He may think you finicky, but he will give you better service, and your patients will never get the impression that your office is down at the heel.

You will be expected to keep the doctor's bag as neat and well equip-

ped as you do the closet shelves. He will furnish you with a list of things he wants to find in it, and will bring it to the office from his car several times a week for you to clean, straighten, and replenish.

Make a study of your patients and their attitude in the examining room and help them tactfully and quietly. Dr. Barrie often jokes with them in a way they like. You can smile and show your amusement, but it is usually best not to enter into the conversation unless addressed. Then do so graciously—but briefly! To create the best impression, make the patient feel that you're wholeheartedly attentive to her needs and wholeheartedly subject to the wisdom and skill of your doctor. Keep the atmosphere as soothing as possible, shut

doors quietly, lay instruments down gently, don't hum or whistle under your breath. And—forgive me for mentioning it—don't chew gum.

You will find that your hands are constantly washing your hands. This little rite must be performed after practically everything you do in the doctor's office. Keep the hand lotion near by and use light nail polish. The fingers that touch the sick should be the best groomed in the world.

Last of all, in spite of these many directions, *preserve your originality*. Interest in your work will keep your mind constantly on the lookout for newer and better methods. You can always improve on the one who has gone before you.

As ever,

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How to Get Along With Your Hospital

More cooperation behind the scenes and less griping in public will go a long way

Do you really *want* to get along with your hospital? There are at least some doctors who talk and behave in a manner that suggests the contrary.

We hear, for example, of physicians who fear that control of the practice of medicine is the hospitals' primary aim. (These doctors may be more interested in *changing* hospitals than in getting along with them.) We also get reports about doctors who hospitalize patients to shift the burden of payment for diagnostic services from the patient to Blue Cross, and then let charges accumulate so that the hospital, not Blue Cross, takes the loss.

On the whole, however, the honest ones are only a small fraction of the profession. Most doctors whose views on the subject are known to me take the sensible view that the hospital is an indispensable tool of medical practice, and it is better to have a good tool than a bad one.

The hospital needs your help in the same way that an airplane needs help from its pilot. Without you it

is nothing. If you take good care of it, it will give you the service you need to perform your function in society.

How, then, can you get along with your hospital and thus make it a better implement to use?

First, it's important to understand that the hospital, as a business, is a misfit in a capitalist society. Hospitals are often compared with hotels. But while a hotel may be operated by the capitalist standard ("what produces a profit is good, and what produces a loss is bad"), a hospital may not.

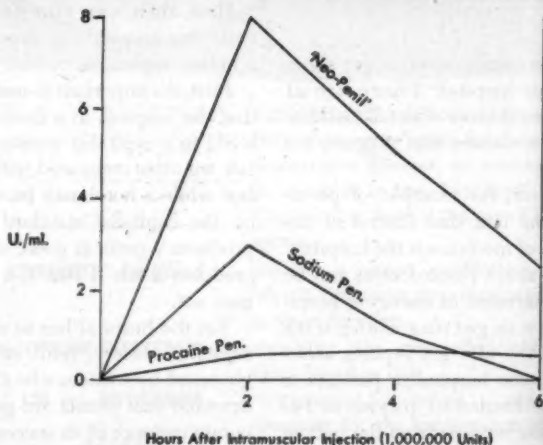
Yet the hospital has to exist in a capitalist society. And it's often governed by trustees who fail to understand that profits are not an accurate measure of its success.

As a business, the hospital may be compared to a department store in which the merchandise is ordered by accident, the customers are hauled in against their will, and the employees are supervised by a group

By Robert M. Cunningham Jr.
**This article, which approximates a talk given before a recent secretaries-editors conference of the Medical Society of the State of Pennsylvania, was prepared by the editor of The Modern Hospital.*

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of strangers over whom the management has little control. What you'd call such a set-up, I don't know. Certainly it's not business as most of us would define it.

What it all adds up to, of course, is that hospitals today are faced with a critically acute financial problem. Prices of everything that the hospital buys have skyrocketed; and the price of hospital labor, which uses up some 65 per cent of the hospital dollar, has soared above the general price index for the whole economy.

True, rates have gone up too. But rates always have a tendency to lag behind costs in the upward spiral. And there is growing resistance to further increases.

Meanwhile, heavier taxes have cut into the amounts hospitals receive in philanthropic gifts from individuals. And the number of indigent patients for whom hospitals are paid at less than cost has grown steadily.

Fortunately, the number of insured patients has gone up; and corporate contributions to hospitals have increased too. Yet every new medical development that occurs makes itself felt in the hospital in terms of more complex and costly operation.

The first step in getting along with your hospital, then, is to understand that its problems are incredibly difficult, compared with those of most businesses. And the second step is to stop telling one another, whenever something dis-

pleases you, that "Things would be different around here if only we had some efficient management!"

You can help the hospital even more if you will stop telling your patients the same thing, or acquiescing when *they* tell *you*. This is another significant way in which the hospital is different from business. In business, management is solely responsible for its own public relations. In the hospital, *you*, even more than management, are responsible for public relations.

Patients naturally look to you for interpretation of their hospital experiences. If a patient complains to you about his hospital bill, for example, and you reply in effect, "Yeah, those people ought to know better!"—what chance has the hospital to defend itself? If, on the other hand, you explain about the complexity and expense of providing



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hospital care, you'll be contributing to the stability of the voluntary hospital system.

In my opinion, your efforts to strengthen and preserve the voluntary hospital system are quite as important as your attempt to hold socialized medicine at arm's length.

If you decide you want to help the hospital interpret its needs and problems to your patients, the way to start is to *inform yourself*. This means finding out a lot of things you probably don't know about the hospital as a business. You should know, for instance, the specific facts about revenue and expenses, charges, collections, and personnel. Only when you have these facts can you understand the problems and explain them to patients.

I'm aware that some hospital administrators think it's none of the doctor's business *what* the hospital does with its money. But most hospital people welcome the M.D.'s intelligent concern.

An understanding of the business operations of the hospital will even illuminate your own relations with it. Your requests for new hospital equipment, for example, will then be far more likely to bear a reasonable relation to what the hospital needs and can afford.

I'm not suggesting that doctors are in the habit of recklessly demanding hospital equipment they don't need. But I am suggesting that most equipment demands be studied more carefully.

The same is true of other items the hospital buys under medical supervision. The money tied up in drug inventories, for example, is staggering. Many hospitals have discovered that they can cut their drug inventories by establishing a standard formulary of a few hundred needed items and by eliminating purchases made to suit individual fancies.

With your help, the hospital can achieve such economies. *Without* your help, it must struggle uphill against heavy odds—and probably antagonize you in the process.

Ways to Cut Costs

Of course, there's more to it than simply helping the hospital economize in its operations. The physician who's aware of his community responsibility knows that the most economical patient is the one who doesn't go to the hospital at all, or who stays there the shortest possible time.

Such a practitioner helps develop preventive programs. He works toward the extension of outpatient services. He avoids hospitalizing patients who can remain at home. He does not let his patients stay in the hospital any longer than they need to.

A closer relationship between medical men and hospital administrations is productive in other ways, too. Many of you have been troubled in recent years by what you view as a tendency among hospital

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people to interfere in strictly professional matters. I can assure you that hospital administrators are troubled about this too. With rare exceptions they have no wish to intrude unless there's overwhelming evidence that you are failing to supervise your membership adequately in such matters as fee splitting, unnecessary surgery, and the granting of surgical privileges to incompetents.

By far the best single recommendation I can leave with you is to meet more often with the hospital people in your communities to exchange information and opinions. Such meetings lead almost inevitably to better mutual understanding. And in the light of understanding, most of the problems that jeopardize good medical-hospital relations tend to fade or disappear. **END**



Trailerite

• Though he has had a crack at nearly everything, Dr. S. F. Lewis, 59, is always ready for something new. So it was no surprise to his wife and two sons when, a few years ago, he decided to give up his 22-year-old Detroit practice and move West. As he tells it, "We landed in Tuc-

son by default—and took up living quarters in the Emery Park Trailer Court (pop.: 48 trailers) by choice."

Now he combines a trailer-camp practice south of Tucson with an office practice in the town. As a vent for his civic spirit, Dr. Lewis has just been elected the trailer town's judge. For recreation he flies his own airplane.

There's a lot to be said, he feels, for part-time trailer-camp practice in Arizona. Night "house" calls can

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elegance...*



JOHNSON'S Baby Lotion amply fulfills the requirements of "a pharmaceutically elegant product." For its physical form is such that it can be applied to the infant's skin easily and pleasantly.

In addition, it is formulated to be bland and effective in the control of skin bacteria, as well as being useful in preventing dryness and chapping.

Equally important is the preventive and therapeutic efficiency of Johnson's Baby Lotion. In fact, thorough clinical studies in leading hospitals have confirmed the value of this preparation in the manage-

ment of common skin affections of infancy.

Johnson's Baby Lotion is a product that you can confidently recommend for its pharmaceutical elegance, as well as for its prophylactic and therapeutic usefulness.

**JOHNSON'S
BABY LOTION**

Johnson & Johnson

be made promptly on foot. You get a stimulating variety of cases ("from scorpion bites to hysterectomies"). A good many trailerites are there for their ailments ("so there's the usual run of arthritis, asthma, and bronchiectasis"). Patients aren't fly-by-nights, as you might expect, and many carry health insurance.

Any disadvantages? A few minor ones. For example, "home nursing is a bit difficult in a trailer. A tub bath or enema, for instance, is difficult to achieve in cramped quarters."

Like other mushrooming trailer camps in the desert around sprawling, fast-growing Tucson, the Emery Park Court is outside the city limits. So its free-wheeling citizens have divided it into wards and set up their own local government, with councilmen, mayor, sheriff, and judge.

"I don't know why I was elected judge," muses Dr. Lewis. "A judge should have passed the bar. I never could pass a bar."

Trailer Camp Justice

While Judge Lewis' kangaroo court has no legal standing, it does mete out public reproofs for violation of local regulations against such things as speeding, loud radio playing, barking dogs, and general nuisances. ("Trials are held in the recreation hall and are as much fun as we can put into them.")

Worst punishment in the book is exile. Chronic nuisances are asked

to hitch trailers and leave the park, thus forfeiting the pleasures of its swimming pool, bathing beauty contests, square dances, pot-luck dinners, and horseshoe tournaments.

Before taking up medicine, Vermonter Lewis tried a variety of careers. He's been a railroad fireman, telephone lineman, lumberjack, painter, salesman, harvest hand, and a Marine in World War I (he was gassed and wounded). He's still a hunter ("thirteen deer so far") and fisherman ("a lot of fish").

Entrepreneur

As a G.P. in Detroit, he recalls, "I had a good practice and went completely broke three times because of injudicious ventures into business and the stock market."

One business venture was an airport that he owned for ten years. There he trained students, flew passengers, and sold planes. As a result, he was ready during World War II to help organize Michigan's Civil Air Patrol, to serve as operations officer, and eventually to command a training squadron.

Not ready yet to settle down on the ground, even in Arizona, Dr. Lewis plans soon to do some more civilian pilot training. His case history indicates a man still fit for it: "I am blond, 5 feet 10½ inches tall, weigh 160 pounds, have a 32-inch waistline. Eyes test 20/20 except for a slight astigmatism due to injury. All anatomy intact except for tonsils and hemorrhoids." **END**

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POTENT FORMULA!

Each 30 cc. (1 fl. oz.) contains:

Thiamine Hydrochloride.....	36 mg.
Riboflavin.....	3 mg.
Niacinamide.....	180 mg.
Pantothen.....	6 mg.
(Equiv. to approx. 7 mg. calcium pantothenate)	
Pyridoxine Hydrochloride.....	6 mcg.
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—in a delightful cola-flavored syrup.
Bottles of 8 fl. oz. and one pint.

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McNEIL

High Potency B Complex in a cola-flavored syrup

- Patients like Sustinex—in fact they won't believe it's a medicine—
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- Can be added to carbonated drinks—or taken straight—either way it's delightful—

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temptation

pops

up

everywhere



WILL-POWER alone is a poor defense against the constant prodding of temptation. That's where DESOXYN Hydrochloride comes in—curbing the appetite, uplifting the patient's morale. Weight for weight, DESOXYN is more potent than other sympathomimetic amines so that *smaller doses* can produce the desired anorexia with a *minimum of side-effects*. One 2.5-mg. or 5-mg. tablet before breakfast and another about an hour before lunch are usually sufficient. In addition, DESOXYN has a *quicker action, longer effect*.

DESOXYN is equally effective as a valuable adjunct in depressive states associated with the menopause, prolonged illness and convalescence as well as in the treatment of narcolepsy and for adjunctive therapy in alcoholism. All pharmacies have DESOXYN in 2.5-mg. and 5-mg. tablets, in elixir form and in 1-cc. ampoules.

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(METHAMPHETAMINE HYDROCHLORIDE, AMPHETAMINE HYDROCHLORIDE)

LONGER
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QUICKER
ACTION

SMALLER
DOSAGE

XUM

Our 'Free-For-All' V.A. Hospitals

CONTINUED FROM 92]

preciably by the V.A. hospital," says Russell B. Roth, secretary of the Erie County Medical Society. "No one is down on the hospital, therefore, for any but broad philosophical reasons.

"We don't object to the hospitalization of those veterans who in good faith can sign the inability-to-work statement. But as long as you make beds available to *any* veteran, you'll fill up the hospital. Then you'll need more beds for the service-connected fellows. If this pattern were expanded, it would be a beautiful way to take over the medical care of a large segment of the American people. Then it would be too late to do any hollering."

Which is why Erie doctors have been hollering already. Through their county medical society, they have passed a resolution soundly condemning the V.A.'s indiscriminate extension of free medical care.

But will such "hollering" have any results? The A.M.A. has been embarded with similar resolutions for almost two decades. From time to time, it has asked Congress to pass a law enforcing the ability-to-pay test. But the lawmakers are no-

toriously skittish about stirring up the wrath of the country's 20 million veterans.

Recently, a special committee of the A.M.A. has been meeting with veterans' groups, and some compromise *may* be in the offing. One possible result: a revision of the hospital admission form to place the penalty-for-false-statements paragraph directly under the ability-to-pay question.

That would be only a psychological improvement, to be sure. More far-reaching improvements would necessitate a change in the attitude of the veterans' organizations, especially at the local level. Meanwhile, most doctors in Erie—and elsewhere—feel that every step in the right direction, no matter how small, is well worth taking. **END**



"Darling, are you sure you want to go through with this?"

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In ethical packages of 20 capsules each, bearing no directions.

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Administrative Medicine: Make It a Specialty!

[CONTINUED FROM 96]

more about the electrical wiring of an oil burner than the average medical director?) What really counts is: Who has the controlling word?

Everything that relates to a hospital affects the care of patients: food, laundry, noise, employe discipline, ventilation—everything. With the best will in the world, no layman can ever quite get the feel of a patient-oriented institution. On the other hand, even the physician who hasn't picked up a stethoscope in ten years never quite loses the medical point of view.

Let's suppose that I'm a pediatrician and that I happen to be chief executive of a medical installation. My laryngologist wants to buy a special tracheotomic cannula. As boss, I have to approve such a purchase. Well, I probably know no more at first about the functions and usefulness of this cannula than a lay administrator. But of this I am sure: I can learn about the gadget a lot more quickly than a layman could.

The present set-up is a bastard one. The lay administrator claims that his decisions are "purely administrative" and that he keeps his hands off such medical matters as the above. But *anything* that affects

a sick person is at least semi-professional.

Separating the medical from the administrative responsibility is nonsense. The layman can assume *only* the administrative function. The M.D.-administrator can do *both*.

Health insurance, group practice, and hospital insurance are expanding rapidly. If the layman can survive the next few years at the top of these enterprises, he will be immovably entrenched. He will have acquired status and know-how; and he will pass these on to junior laymen. Physicians will be working for him—and on his terms. In his private conclaves with other laymen, he will say: "Doctors are a dime a dozen; but a good administrator is a jewel beyond price."

The solution: Recognize administrative medicine for what it is—a specialty for physicians, calling on the best skills and training that an M.D. can acquire. One university already has a course in medical administration, geared principally for doctors. Other schools can follow.

An "Academy" or other organization of physician-administrators can be formed to organize training facilities and to police the new specialty. Competence can be tested, recognized, and formally certified.

One thing is certain: We are soon going to witness the birth of a new medical specialty; or, by default, we shall have to surrender control of our own installations to the lay executive.

END

Bacterial count per cc.

2000

average count after
soap and water
washing (1,937)

70-second wash
with Bactine
(20% solution)
causes rapid drop
in bacterial count

1500



Rapid and prolonged disinfection
for skin preparation
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BRAND - Reg. U.S. Pat. Off.

Here is evidence of the powerful and
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that has given it an important
place in the operating room and
in the physician's office.

1000

**rapid, prolonged
disinfection of
hands with Bactine**

(Subjects carried on
usual activities involving
recontamination during test)

prolonged action of
Bactine — bacterial
counts at various
intervals after
Bactine wash

RAPID

PROLONGED

Time (hours)

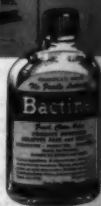
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2

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5



Bactine:
Available in 1-gallon,
1-pint, 5-ounce and
1 1/2-ounce bottles.
From your regular supplier,
or we will assist you
in ordering.

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Why Not Split Fees?

[CONTINUED FROM 79]

wouldn't a surgeon be *required* to refer a patient pre-operatively to a qualified diagnostician? Or are surgeons the final word in diagnosis as well as in surgery?)

Anyway, after having completed his diagnosis, the G.P. makes all hospital arrangements and spends the rest of the night getting Mr. Jones safely lined up for surgery. He inspires the family with unfaltering faith in the very special skills of Surgeon Smith, who is to operate. Of course, the G.P. himself might do a decent job, but he's too much interested in Mr. Jones to take chances.

Next, the G.P. calls in the anesthetist. This fellow also has had much special training, and his responsibility equals that of the surgeon. He, too, is a board diplomate.

\$500 for the Surgeon

All three meet in the operating room. Surgeon Smith believes the G.P. has made an excellent diagnosis. As a special reward, he thinks it would be nice for the G.P. to scrub in. All three start work about the same time. All three quit about the same time.

The G.P. accompanies Mr. Jones to his bed and consoles the Jones family. He assures them that Surgeon Smith did a masterful job.

Because of his interest in the Jones family, the G.P. thereafter makes daily P.O. calls. Of course, these are really "social calls" and not necessary—because Dr. Smith makes all the necessary calls, you know.

Comes the first of the month, and Dr. Smith sends a bill for the \$500 he estimates his services were worth. The anesthetist, a nice fellow, is happy to settle for \$35 or \$50. If the pinch has not been too severe on the Jones family, the G.P. thinks that maybe he should get \$10 for the night call and \$25 for assisting. Or maybe he should forget the whole thing, because the Joneses have been hit pretty hard.

Comes the following year. Young Jimmy Jones gets a pain in his right side and Mrs. Jones thinks it's appendicitis. Mr. Jones has ideas like those I had on leaving medical school. He says, "Why mess around with the middleman? We'll take him to Dr. Smith direct." Next day the G.P. learns to his dismay that now the Joneses just call him for ordinary things like baby cases, or night calls, or maybe a heart attack or a case of lockjaw.

Does Dr. Smith tell them that their G.P. is quite able to handle a case of appendicitis himself? He does not. He's merely grateful to the G.P. for having placed him in the everlasting confidence of the Jones family. The G.P. didn't need that appendectomy anyway. Or did he?

[MORE→]



Why the Velvet Glove?

The "clenched fist" (of effective antibacterial action) can deliver just as effective a knock-out blow, even if it wears the "velvet glove" (of virtual freedom from adverse side effects).

For urinary antiseptics, Mandelamine provides both of these clinical advantages:

... BROAD SPECTRUM ANTIBACTERIAL POTENCY

Published studies^{1,2,4} show the wide range of Mandelamine's effectiveness—against all the most common urinary pathogens, even against many organisms resistant to other drugs. "Comparative studies . . . indicate that its effectiveness is of approximately the same order as that of the sulfonamide drugs or of streptomycin."¹

... VIRTUAL FREEDOM FROM ADVERSE DRUG REACTIONS

The use of Mandelamine is "seldom associated with untoward effects . . . toxic manifestations are relatively rare."¹ It is notably free from agranulocytosis and other blood dyscrasias, cutaneous eruptions, anorectal complications, and neurotoxicity . . . from encouraging monilial or trichomonal infestations or inducing drug fastness in organisms.

More than a decade of increasing clinical use shows YOU CAN HAVE BOTH . . . and

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SUPPLIED: Tablets, enteric-coated, containing 0.25 Gm. (3½ gr.) methanamine mandelate—bottles of 120, 500 and 1000.

DOSAGE: 3 or 4 tablets t.i.d. for adults—children in proportion.

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REFERENCES:

1. Amer. Medical Association Drug and Hospital Remedies, J. B. Lippincott Co., Philadelphia, 1951.
2. Carroll, G. & Allen, W. M.: J. Urol. 52:674, 1946.
3. Kierke, T. J. & Bodiger, J. P.: Am. J. Surg. 52:477, 1941.
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Were physicians to follow the same principles of ethics and procedure as American business, Dr. Smith would be allowed to accept only such complicated cases as were referred to him by the middleman-G.P. Thus, the G.P. could count on finding at least a little wheat among the chaff.

Permit patients to go direct to specialists, however, and what is left for the vanishing G.P.? Nothing but scraps. Yet we are told that the general practitioner is the backbone of American medicine!

Patients Don't Care

Those who lead the fight against fee splitting insist that the patient must know exactly how much money each doctor receives. But the patient isn't *interested* in this detail. Nor does it tend to reduce his ultimate cost. In fact, many patients ask to pay everything through one source because it's easier that way.

We send a patient to the hospital for ECG studies. The hospital bills the patient for \$10. According to the rationale used in surgery, the hospital, as a matter of ethics, should note on the bill that Dr. Jones receives \$2 for reading the ECG and that \$1 is paid to the technician for running the test.

Recently Uncle Sam has entered the picture via the Bureau of Internal Revenue. He agrees with the surgical hierarchy that fee splitting is nefarious, unholy, and to the detriment of the public. He has gone

so far in some cases as to determine the upper limits of a fair fee for assisting at surgery. Next year, maybe, we'll find the door open for Government regulation of *all* fees.

In holding over fee splitters the income-tax shillelagh, Washington, it's said, wants merely to protect the long-suffering public. Yet little is done to protect the public by restricting surgical fees. For the surgeon, the sky is the limit. The G.P. just isn't supposed to get in on the act.

Yes. Fee splitting is a very bad practice—for the surgeon. But for the G.P. it is necessary to existence. And to the patient it makes no difference.

May the A.M.A. and Uncle Sam move slowly in the matter till the spell of the surgical masters' magic wand has been dissipated! **END**



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See the difference when an elastic bandage is *truly* elastic?

the bandage on the left is TENSOR
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As you can see, TENSOR has far more stretch and snap-back than conventional elastic bandages. That's because TENSOR—derives its elasticity from *live rubber threads*—does not depend on the weave of the fabric as rubberless bandages do.

You can see the difference, too, when you apply TENSOR. It maintains the tension you select—firmly, constantly. And it stays put without frequent adjustments, gives the patient greater mobility and comfort.

Isn't this difference in elastic bandages important to *your* patients?

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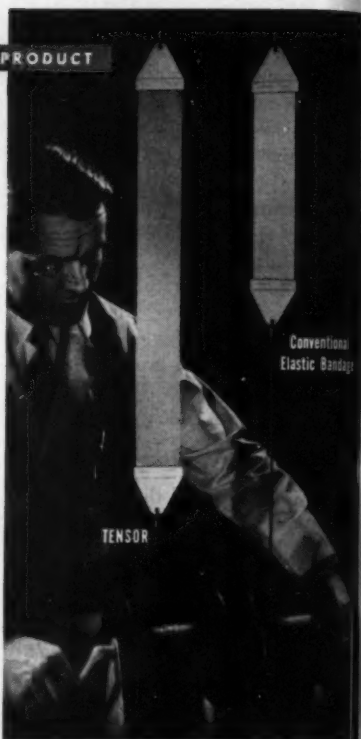
woven with live rubber thread

(BAUER & BLACK)

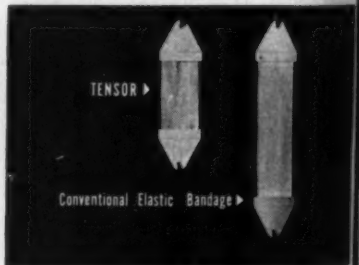
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STRETCHED TO LIMIT, identical lengths of TENSOR and conventional elastic bandage display big difference in elasticity. *Live rubber threads* give TENSOR its greater stretch.



WHEN SLACK AGAIN, TENSOR returns to its original length—and will do so even after repeated use and washing.

A Psychologist Goes To the Doctor

[CONTINUED FROM 69]

a question that a patient may hesitate to answer truthfully. And the way Dr. Malahan asked it made me think he'd disapprove if I said yes. So I lied. For this I make no apology. The insurance company will have to figure out the discrepancy.

The way you phrase a question, of course, largely determines how much the patient tells you. But another factor also made me more inclined to give information to Dr. Bonham. Unlike Dr. Malahan, *he let me finish my sentences.*

Dr. Malahan's abruptness only confirmed what I've heard from other patients—that doctors are the greatest interrupters in the world. Is it possible that the medical profession has so little respect for what its clients have to say?

Another thing about Dr. Malahan that bothered me was his choice of vocabulary. To avoid medical terms entirely, he went to the other extreme. He referred to my more intimate parts and functions in a basic English that startled and sometimes offended me. I like to think I'm broad-minded, but I can't believe that most men like to hear Army terminology from a doctor. Without using professional language, a phy-

sician ought to be able to translate what he means into common words, without being vulgar.

The doctor should, I feel, take into account his patient's reticences and sensitivities. Take, for instance, the problem of undressing. Neither of the two doctors handled the disrobing act quite to my satisfaction. Dr. Bonham had me strip completely except for shoes and socks. Dr. Malahan had me open my shirt, then button it up, then take off my trousers and shorts—a sort of piece-meal strip tease.

My own reaction was that I'd rather be examined completely nude. To be left partly dressed, wearing just one or two unbecoming garments like a shirt or shoes and socks, makes me feel absurd.

The Naked and Their Dread

My friends, I've found, support this all-or-nothing stand. And to my surprise, women agree even more emphatically than men. Perhaps it's vanity; but people seem to feel more at ease in a natural state of nudity than when they're—so to speak—caught with their pants down.

Above all, they don't want to be "caught" by anybody but the doctor! We patients want our privacy respected. We want no doors left ajar, no strangers barging in and out, *please!*

A friend of mine who is sensitive about his excess poundage was being examined as God made him, when two strange doctors burst in

75% LESS NICOTINE

Than 2 Leading
Denicotinized Brands

85% LESS NICOTINE

Than 4 Leading
Popular Brands And 2
Leading Filter-Tip Brands



**John
Alden**
CIGARETTES

Test Results

A comprehensive series of smoke tests* were made by Stillwell & Gladding, New York City, one of the country's leading independent consulting laboratories, on John Alden cigarettes, 2 leading denicotinized brands, 4 leading popular brands and 2 leading filter-tip brands. The results disclosed the smoke of John Alden cigarettes contained:

At Least 75% Less Nicotine Than The 2 Denicotinized Brands

At Least 85% Less Nicotine Than The 4 Popular Brands

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Importance to Doctors and Patients

John Alden cigarettes offer a far more satisfactory solution to the problem of minimizing a cigarette smoker's nicotine intake than has ever been available before, short of a complete cessation of smoking. They provide the doctor with a means for reducing to a marked degree the amount of nicotine absorbed by the patient without imposing on the patient the strain of breaking a pleasurable habit.

AN ENTIRELY NEW VARIETY OF TOBACCO

John Alden cigarettes are made from a *completely new variety of tobacco*. This variety was developed after 15 years of research by the Kentucky Agricultural Experiment Station. Because of its extremely low nicotine content, it has been given a separate classification, 31V, by the U.S. Department of Agriculture.

**A summary of test results available on request.*

*Also Available: John Alden Cigars
and Pipe Tobacco*

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Send me free samples of John Alden Cigarettes

Name _____ M. D.

Address _____

City _____ Zone _____ State _____

FREE PROFESSIONAL SAMPLES

to consult a book and settle an argument. He resented the intrusion, of course, but even after they had left he couldn't stop thinking uneasily: If *they* had free access, what's to keep out the receptionist?

Point of No Return

As I left Dr. Malahan, he failed to volunteer any information about the results of the examination. Instead of satisfying my curiosity, he merely said he'd send the blank to the insurance company, and waved me out of the room. His receptionist, of course, bade me a cheerful good-by.

Dr. Bonham, on the other hand, took time to give me a brief résumé of his findings. He told me that he would keep a record of my examination in his files; and later, if I had any questions, I could call him.

Despite the poor reception situation in his office, I feel now that I'd like to consult Dr. Bonham when I need medical attention again. In the end, it's the doctor himself who really matters.

END



"And just before I went under the ether I thought, 'Cad! I may never see a human face again!'"

in Others' Words

A Retired Woman Physician:

"The recent editorials together with Dr. Cline's monthly messages have set before us historical facts and important conclusions.

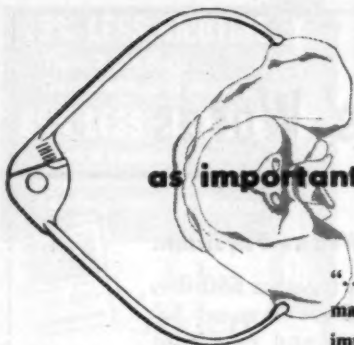
"Total permanent disability obliged me to retire at 61 years of age five years ago. Having dependents I am unable to contribute to the Foundation as are physicians in active practice, yet I am aware of the truth of Dr. Cline's statements and the weight of his conclusions and send herewith a small check."

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Niacinamide	20.0 mg.
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Cobalt	0.033 mg.
Copper	0.33 mg.
Iodine	0.05 mg.
Manganese	0.33 mg.
Magnesium	1.0 mg.
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Potassium	1.7 mg.
Zinc	0.4 mg.

*Equivalent to 15 gr. Dicalcium Phosphate Dihydrate.

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The Newsvane

Assert Doctors' Right to Delegate Hospital Tasks

Should a hospital lay down rules on what duties a doctor may delegate? No, says a committee appointed to study the subject for the staff of Providence Hospital, in Oakland, Calif.

Originally the committee was asked to draw up an official list of procedures that might be delegated with the hospital's sanction. But the final report includes no such list. Instead, the committee's recommendation boils down to a simple precept: The hospital should leave such decisions up to the physician.

"Any rule or regulation that [limits] any privilege of a physician] defeats the primary function of a hospital: [which is] to facilitate the treatment of a patient by his physician," the report states. "The limiting rule becomes a substitute for the doctor's judgment of individual factors in a case."

Legally, according to the committee, only physicians should administer anesthetics or give a hypodermic. So when a doctor turns these functions over to a nurse, it is with "full understanding that he may be held responsible in a malpractice action." But, the report adds, reason and pre-

cedent justify the physician's freedom to delegate, which is "desirable from the standpoint of patient welfare, and in keeping with the standards of practice in any community."

Suppose, however, that a physician distinguishes himself for lack of judgment. What is to protect his patients and the standards of medical practice, if not hospital rules? The committee's answer:

"Where discipline or restriction seems indicated, the members of the staff should assume this responsibility." But in general, the report concludes, the hospital should allow the doctor to delegate "anything he orders. He's the responsible party."

A 'Waste of Time' to Warn Public of Disease Risk?

Alerting people to the deadliness of a disease won't save them from dying of it. So the "ballyhoo" type of campaign for mass education is a waste of time, money, and effort. This is the astringent view of Dr. Max H. Weinberg, as set forth in *The Pennsylvania Medical Journal*.

Actually, the energy put into such campaigns is worse than wasted, he says. "It merely tends to upset the unstable and the neurotic elements."

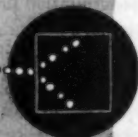
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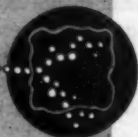
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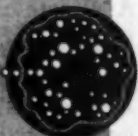
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more about the danger of metastasized cancer, Weinberg points out, than any publicity campaign could tell the public. Yet a recent study of thirty-seven physicians found to have cancer reveals that thirty of them took no early steps to save themselves from serious involvement. It is, then, says Weinberg, a fallacy that "knowledge of the seriousness of a condition per se is an aid to prevention and a stimulus to seek prompt medical care."

He admits that it's logical to expect informed persons to troop to their doctors at the first warning symptom. But, he observes dryly, "Human behavior is very seldom based on logic. Emotional factors play a greater part." Forty years of practice have convinced him that most people postpone medical care till they're seriously ill, though fully aware of the risk.

Educational groups of mixed lay and medical membership get no sympathy from Dr. Weinberg for their efforts to combat serious disease. His final word of advice to physicians: Don't "encourage . . . the formation of these organizations, [much less] take an active part in them."

Latest Diagnostic Aid: Handwriting Analysis

You can tell more than the size of a patient's bank account from his handwriting. For example, says Dr. M. W. Thewlis of Wakefield, R.I.,



M. W. Thewlis

Sign here for diagnosis

handwriting can reveal a person's emotional condition.

Dr. Thewlis, who claims that graphology is an important diagnostic tool for the physician, reports that samples of handwriting taken at various stages can help plot the progress of treatment. To show how graphology helps spot emotional disturbance, he cites the story of a young woman inmate of a hospital for the mentally ill. Her handwriting showed no evidence of serious illness. Then why was she there?

When he learned that she had been committed, without prior examination, on her husband's lurid account of her condition, Thewlis studied a sample of the husband's handwriting. As a result, he decided that the man was a potentially dangerous paranoiac. Not long after-

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ward, the husband shot his wife and children and committed suicide.

As a geriatrician, Dr. Thewlis finds handwriting analysis especially helpful. The penmanship of the aged, he says, may help a physician separate the merely senile from the mentally unbalanced.

For the past three years, the New England M.D. has been preparing a book on the medical uses of graphology. "The idea is unique in medicine," he says, "but in time I think it will be used more and more."

Says Hospitals Don't Need Doctor at Helm

The claim that physicians make better hospital administrators than non-physicians has been challenged by Dr. Lucius W. Johnson, former hospital visitor for the American College of Surgeons. A medical degree, he points out, is no guarantee of success at running a hospital.

M.D.-administrators rate from A-plus to F-minus, as he sees them, but the low grades outnumber the high ones. In an article in *The Modern Hospital*, he reports that a survey of more than 300 hospitals shows that some of the very best are run by doctors—but also some of the worst.

Selecting four hospitals as "sterling examples of mismanagement," he found that three had physicians as administrators. Next he checked the institutions that were "shining examples of skillful supervision"; in

only one case was the head man a doctor. Box score for M.D.-administrators: one-fifth of the good examples, three-fourths of the bad.

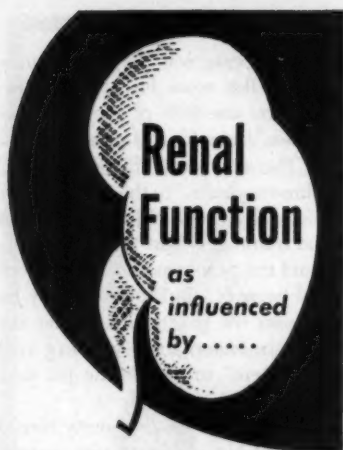
"There is considerable validity," Johnson admits, "to the idea that the doctor, by virtue of his education and training, is best fitted to understand the problems of patients, staff and trustees." But to this theory he opposes the practical fact that not enough doctors are "willing and competent" to handle the job as a whole.

One reason for the spotty record of physician-administrators, according to Lucius Johnson, is their tendency to guide the hospital with one hand and take care of their practice with the other, "in competition with the rest of the staff."

What, then, if not a medical degree, makes for competent administration? "Personality and ability to sell an idea account for 75 per cent of success," Dr. Johnson concludes. "Leadership and understanding of people are more important than educational background."

Blue Shield Blossoms Out As M.D. Pay Source

The fast-growing importance of Blue Shield as an income source for doctors is evidenced in a recent report from United Medical Service, New York City's local Blue Shield plan. Latest figures indicate that in 1951 about a thousand M.D.'s received more than \$1,000 each from



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U.M.S. And more than a hundred of these got over \$5,000 apiece.

Total payments for the year exceeded \$3,600,000, a jump of more than 56 per cent over the figure for 1934—thus proving that voluntary health insurance now gives substantial support to the medical men who've been supported it.

Some 5,200 physicians share this tidy sum. Of these, 181 received from \$3,000 to \$5,000 apiece. The average take for the 106 doctors whose U.M.S. receipts were over \$5,000 came to more than \$7,700.

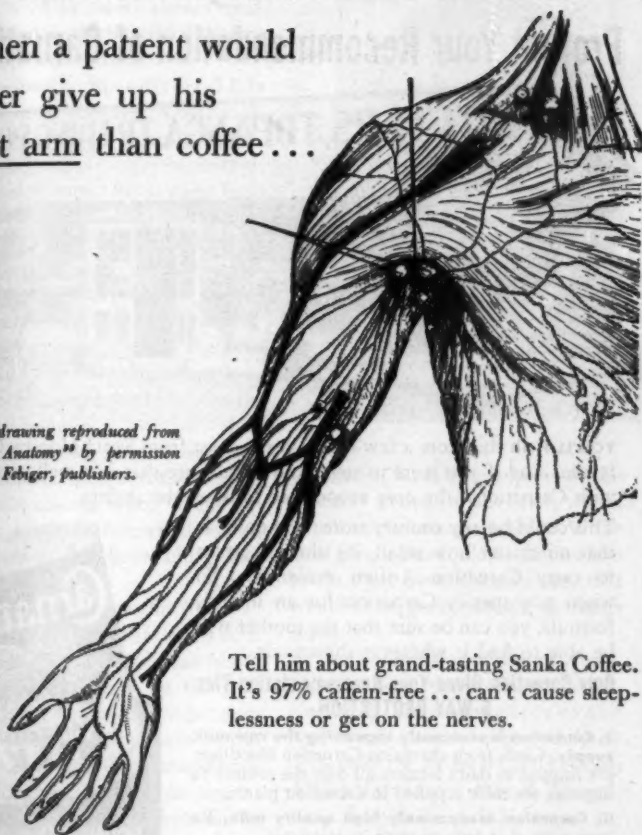
Shelve Staff Men at 65? Doctors Disagree

Compulsory retirement from hospital staffs at the age of 65 has stirred up a controversy in the Detroit Medical News. In an editorial not long ago, Dr. Dave Sugar struck the blow. "By what rule of reason and common sense," he asked, "is a man able to be head of a medical or surgical service at 64 years and 365 days, and the next day be... a has-been?"

There is, he maintained, a wide difference in vigor among 65-year oldsters; for the sixty-fifth birthday is a "variable and shifting milestone." While in some it postdates an era, in many it is but another day in a busy, useful life."

The compulsory retirement idea Dr. Sugar pointed out, stems from business and industry, where "the big accelerating waste of our mechanical age is the loss... of those who have only by the decree...

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time been relegated to the junk heap." Why, he asked, should medical men allow the industrial pattern to be imposed on them?

An answer to the editorial has come from Dr. Kenneth B. Babcock, director of Detroit's Grace Hospital, where retirement at 65 is compulsory for staff men: Retirement from the staff needn't end a physician's career, he suggests. "Nobody has taken away the privilege of practicing medicine or surgery and the enjoyment of a full life."

Dr. Babcock maintains that the retirement plan helps "industry, business, and hospitals build for the future," by bringing in new personnel to replace the old. The arbitrary age limit protects such institutions, he says, from anyone who, "in his desire for power or honors, does not know how . . . to grow old gracefully."

He says he discusses this "touchy" subject with his staff in terms of a football team. Thus: The man of 65, after having his turn on the first team, is expected to let younger men carry the ball while he stays on the sidelines as coach and consultant. Approached in this way, he insists, "I have never known a physician to be resentful."

Your City Ready for an A-Bomb?

Suppose an A-bomb burst over Main St., your town, tomorrow morning. Would your local civil defense or-



Norvin C. Kiefer

Organize, not glamorize, C.D.

ganization be able to cope with the disaster? More important, would you be able to cope with it? While most physicians could be counted on to do their best, chances are, that wouldn't be good enough, as things stand.

That's a frank appraisal of America's medical preparedness, as Dr. Norvin C. Kiefer, director of the health and special weapons defense division of the Federal Civil Defense Administration, sees it. Though state and Federal C.D. units are preparing for 3 million civilian casualties in the event of atomic attack, medical organization at the local level is lagging badly, says Dr. Kiefer. Local leadership, he points out, "must come from the physicians."

While a great many doctors are currently active in civil defense

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training, Dr. Kiefer feels that in some cases their activities are misdirected. Many M.D.'s, he says, are interested only in the more "glamorous" technical aspect of civil defense and, as a result, neglecting their local casualty and first-aid units—the ones that must be counted on for yeoman's work in the event of enemy attack.

"Without doubt," he says, "counting in the effects of atomic weapons, in the grim possibilities of biological warfare, and in the startling properties of nerve gas have the most appeal." But, he adds, the real need is in those areas of civil defense organization "where a more basic, but somewhat less stimulating, show goes on."

Kiefer confronts doctors with this question: "Which would you rather have if an atomic bomb hit your city: a casualty service with little advanced technical training but as well organized that it could be mobilized within minutes... or a group of highly trained experts in the details of care of radiation sickness and other unusual conditions, who had no concept of total mobilization? Frankly, I'd rather have both combined in one, but with a choice... I'd far rather have the well-organized group."

To point up the magnitude of civil defense medical needs, he gives this breakdown of the manpower requirement for a 120-station first-aid setup in a city of a million people: 360 physicians; 240 dentists and veterinarians; 360 nurses; 3,600 first-aid field workers; 12,600 litter

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bearers; 12,200 ambulance personnel, clerks, etc. Total: 29,000!

Supply-wise, the nation is presently equipped to treat fewer than the 2 million living casualties expected in the event of atomic or biological attack, the Federal director reveals. But the stockpiling operation is moving ahead rapidly at Civil Defense Administration warehouses. Of the \$58 million earmarked for C. D. health supplies in 1952, about \$49.5 million has already been spent.

But as soon as the \$58 million has been used up, civil defense authorities will be faced with new supply problems. "Because of assumptions of increased enemy capabilities in the intervening year," says Kiefer, it is now estimated that supply stockpiles should be more than doubled during 1953. If Congress is willing, an additional \$193 million for health supplies will be available by the end of next year. If this money is spent, there will be enough supplies on hand to care for 3 1/3 million surviving casualties.

But, Kiefer warns, these supplies are expected to last for only the first two weeks after mass enemy attack.

Do You Enjoy Drinking? That's Fine, But . . .

All except the most narrow-minded will agree that there's no harm in bending an elbow with your colleagues now and then. But alcohol and medical meetings don't always mix smoothly, warns Dr. C. E. Ervin,



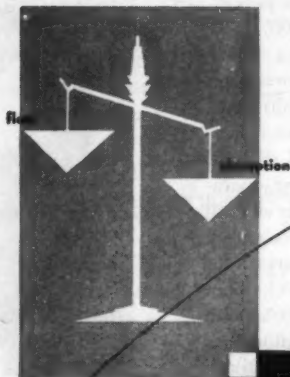
C. E. Ervin

Business before ethylation

of the Harrisburg (Pa.) Academy of Medicine.

For one thing, he says, there's the general public to consider: "The doctor has a right to his inning, but it serves no good purpose to have the behavior of an ethylated physician described . . . at the Wednesday afternoon bridge club." After one shindig he heard a woman remark: "You should have seen the doctor fall flat on his face right before my eyes." So he recommends holding primarily social events in "a place where no laymen are admitted."

As for social drinking in connection with scientific or business meetings, there are still other problems, says Ervin. When the Harrisburg Academy began serving cocktails and dinner before its regular meetings, the idea was a whopping suc-



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*Am. J. Obst. & Gyn., 31:979, 1936.

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cess. "Unfortunately," he reports, "the attendance at the meetings has not measured favorably with the attendance at the social hour . . . At the present rate, it will not be long before the scientific program is overshadowed by the social hour."

Time for Blue Shield To Check Its Course?

Is Blue Shield headed in the wrong direction? It's entirely possible, says Dr. John W. Cline, past president of the A.M.A.

Noting an increasing demand for catastrophic coverage, he thinks that "many plans have stressed minor illness to too great an extent."

Mindful of the "many developments we did not foresee," Dr. Cline advises Blue Shield planners not to be dogmatic. "It often surprises me," he says, "to observe the assurance with which certain people express themselves concerning the exact

course our plans should follow."

To illustrate his point that it's sometimes necessary to "revise our thinking," Dr. Cline relates the early experience of the California Physicians' Service, which he helped to create. "It began," he recalls, "with the assumption that it was required to produce a variety of coverage . . . It was assumed, also, that a certain premium would cover certain services . . . Before corrections were made, the plan became almost insolvent because the original assumptions had been erroneous. As time passed, it was necessary to limit coverage and increase rates."

The former A.M.A. president says that many other health insurance plans may have to shift course in the face of changing winds. He thinks they will probably find it advisable to stress coverage of major illnesses through a co-insurance feature whereby Blue Shield and the subscriber will each pay part of every

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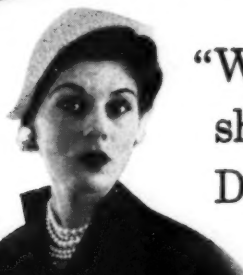
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bill. "When one entirely eliminates individual patient responsibility, the difficulties and abuses of any plan multiply," says Dr. Cline.

'Hospital Administrators Must Adjust to Doctors'

Doctors are "intractable individualists," and hospital administrators must learn to adjust to that fact. This, strangely enough, is the verdict of the very people whom you might expect to resent it: leading hospital administrators.

In an article in *The Modern Hospital*, Dr. John Correll, director of the hospital administration division of Columbia University's School of Public Health, tells of a recent poll of twenty-five hospital administrators, none of whom was a doctor. Of those queried, twenty-three believed that their staff doctors have "different concepts of society" than do other hospital people. Twenty-two said flatly that the chief difference is that "doctors are individualists."

How do physicians "get that way"? Most of the administrators apparently feel that the average doctor enters medicine because he's an individualist to begin with. "The young person who becomes interested in medicine," explains Dr. Correll, "is often motivated by hero-worship [and] admiration for those people who do things *alone*."

Correll advises all hospital administrators to plan their work accord-

ingly. The doctor's individualism, he says, "must not only be recognized but accepted and used in intelligent administration."

He adds: "The discovery and willingness to accept individualism as the outstanding characteristic of the doctor . . . is indeed the direction signpost we need." The administrator, he says, must learn to utilize the physician's "professional and personal traits . . . We [in hospital administration] must do virtually all of the adjusting for the present."

Why Don't ENT Men Wear Hats? Is It a Trap?

After reading one of the more unusual health surveys of recent years, the editors of the *Rhode Island Medical Journal* began to see the light.

The survey in question was conducted by *Hat Life*, a publication representing the hat-making industry, and was read into the *Congressional Record* by the Congressman from Fairfield County, Conn., "the hat center of the world."

Hat Life, according to its report, asked 100 nose and throat specialists this question: "In your opinion, does a hatless man particularly invite sinus trouble?" Of the twenty-two specialists who replied, fifteen reportedly answered in the affirmative.

Thus enlightened, the *Rhode Island journal* comments: "We . . . have been undone by one of our local nose and throat men. We never



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thought of going about . . . hatless until we discovered the fact that Dr. S was [doing so] . . . Now we realize that he had a deep-laid diabolical plot . . . He was evidently, by his sinister example, leading others to accumulate sinus trouble. Thus he fattened his pocketbook."

The journal concludes by asking, "Isn't it just possible that the . . . fifteen nosologists, influenced by their personal friendship for the 'Danbury Hatters,' have been led into talking through their hats?"

Want to Buy a Bargain in Medical Equipment?

The doctor's rich uncle (Sam's the name) is willing to pay, in some cases, more than half the cost of a new X-ray machine or other piece of medical equipment. That's the sales pitch that Darton E. Greist of the Professional Equipment Co., New Haven, Conn., offers alert surgical supply salesmen.

With doctors' income taxes at unprecedented levels, he advises salesmen to remember to sell tax savings along with their product.

In a recent article in the *Journal of the American Surgical Trade Association*, Greist points out that the salesman who uses this pitch really owes the physician a favor; for, he argues, as long as the Government continues to assume a "surprisingly large share of the cost," medical equipment is a rare "bargain."

Uncle Sam doesn't, of course,

make his "contribution" in a lump sum; rather, Greist explains, he kicks in over a ten-year period through the depreciation deductions allowed. Greist points out that by the end of the ten years, the yearly tax savings on a \$5,000 purchase will equal from 35 per cent (on a \$10,000 net income) to 63 per cent (on a \$26,000 net).

Medical Families Take to Catastrophic Policy

Enrollment in a catastrophic coverage plan for doctors and their families is moving along at a good clip, reports the journal of the Connecticut State Medical Society. "To the best of our knowledge," it adds, "such insurance has never before been offered to a medical society group."

Under an arrangement with the Commercial Insurance Company of Newark, N.J., the plan covers up to \$5,000 in medical expenses incurred by a member doctor or his dependents as a result of accident or sickness. Payments totaling 80 per cent of the actual expense (excluding the first \$500) will be made for medical, surgical, hospital, and nurse services, and "all other therapeutic services and supplies." A doctor and his wife are eligible for the coverage until the age of 70, and their unmarried children are insured until their twenty-third birthday.

Under the group arrangement, the policy costs \$75 a year if a phy-

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sician wishes to insure himself and more than one dependent. For a doctor with only one insured dependent the annual rate is \$60, and the cost to a single physician is \$32 yearly.

Streamlined Diagnosis Urged by A.H.A. Head

Hospitals must streamline their diagnostic services if they are to provide "the best in medicine," says Dr. Anthony J. J. Rourke, president of the American Hospital Association. They are overcrowded, he points out, partly because certain Blue Cross and Blue Shield benefits "become available to hospitalized patients when they are not available to ambulatory patients."

And because present diagnostic procedures in the hospitals move at a "snail's pace," they are, he goes on, needlessly expensive for both patient and hospital. His solution: a "belt-line production" of rapid diagnostic services for ambulatory patients "which will be available to any doctor whether he practices in a group or alone."

While doctors would be expected to help develop such stepped-up procedures, they would not be called on to take any short cuts themselves. The "belt-line" concept cannot be applied to that part of diagnosis that involves the "education, training, experience, and judgment of a qualified physician," the A.H.A. head points out. But "with purely admin-



Anthony J. J. Rourke
Speed up the 'snail's pace'!

istrative techniques in traffic management . . . [we can] apply the most modern methods of rapid transit."

A diagnostic service for out-patients, Dr. Rourke believes, would eliminate "the heavy cost of nursing service around the clock, the heavy expense associated with meals in bed, the expensive telephone service, the operation of elevators, and a host of other expenses." He adds: "In many diagnostic problems, under our present methods, twenty-three hours may be wasted" in a hospital bed "for every hour of professional consideration."

Doctors and hospitals should work out the operational details of any "belt-line" diagnostic service, says Rourke. But, he suggests, the prepayment plans should "add the stim-

in penicillin reactions...

NEW, "remarkably effective" treatment

Decholin Sodium and Decholin

(brand)

(brand)



Gratifying results are reported^{1,2} with *Decholin Sodium* and *Decholin* in treating penicillin reactions of the most commonly encountered type—with symptoms simulating serum disease. The treatment "has not failed so far in any patient with serum-sickness type of penicillin sensitivity."³ Most of the patients in this study had been given a variety of other medications without success prior to the successful use of *Decholin Sodium* and *Decholin*.

SYMPTOMS: Fever, itching, joint pains, urticaria, edema, hoarse or tight throat and other serum-sickness types of penicillin reactions respond promptly to this new therapy—relief is usually complete within an average of four days.

TREATMENT: Subject to adjustment by the physician, a routine schedule is to inject 5 cc. *Decholin Sodium* intravenously, once daily or every other day (depending on degree of sensitization), also one tablet of *Decholin* three times daily.

Decholin Sodium (brand of sodium dehydrocholate) 20% aqueous solution for intravenous injection; ampuls of 3 cc., 5 cc. and 10 cc.

Decholin (brand of dehydrocholic acid) Tablets 3½ gr. (0.25 Gm.) in bottles of 100.

Decholin Sodium and *Decholin*, trademarks reg.

1. Peiser, L., and Waldman, S.: *Postgrad. Med. J.* 49 (Jan.) 1953.

2. Peiser, L., and Waldman, S.: *Am. Pract.* 3:293 (Apr.) 1953.



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XUM

ulus by developing ways and means of writing coverage and furnishing finances."

More State Regulation Of Blue Shield Urged

The fact that the parent Blue Shield plans were born in a depression doesn't mean that they can survive another bread-line era. It's entirely possible, in fact, that some of the doctor-sponsored health insurance plans now in operation would go bankrupt in the event of a national economic recession.

So says Frank Sullivan, president of the National Association of Insurance Commissioners. He urges that the Blue Shield plans hasten to strengthen themselves before a depression and/or the Federal Government gets them.

How can the plans best grow stronger? By "submitting . . . to state regulation in all states," says Sullivan.

As things stand, he points out, many of the plans operate with "a complete absence of regulation or a minimum of regulation." Four states, he notes, do not regulate Blue Cross-Blue Shield at all; and in forty states the "regulation varies from adequate to inadequate." This means, in many cases, that the plans are not required to have cash reserves that would protect the public in the event of a depression; nor, in states where there is inadequate regulation, do the plans' contracts and

practices "meet the tests of law which are met by the various insurance companies performing a similar service."

Why is state regulation of health insurance especially important at this time? Because, says Sullivan, some of the prepay plans are operating on an interstate basis—and that makes them subject to the McCarran Act. Under this Federal statute, the Government can take charge of the plans that cross state lines if there's "insufficient regulation at the state level," says the insurance man. So by not encouraging state control of their affairs, the health insurance plans are "inviting the Federal Government to come in."

Though Blue Shield people will recoil at the sound of the word "regulation," they have nothing to fear, according to Sullivan. State regulation "need not be oppressive and constrictive," he says; certain Blue Shield plans already under full state regulations "are excellent proof of that fact."

Escalator Schedule Curbs House Call Pleas

A fee schedule that makes patients think twice before making unreasonable requests for house calls has been adopted by Fredericksburg (Va.) doctors. Its chief feature: an allowance for steep increases that can boost the fee for inconvenient house calls to \$15 or more.

The minimum for office calls is

Diarrhea?

SURE, IT IS ONLY A SYMPTOM . . . BUT

The Patient Clamors for Relief



Arobon contains no chocolate; yet, when stirred into milk, it makes a palatable drink of chocolate-like flavor. Adult dosage, 2 level tablespoons in 4 oz. of milk every three or four hours. Children, 1 level tablespoonful in 4 oz. of milk.

ADDITIONAL REFERENCES

Smith, A. E., and Fischer, C. C.: The Use of Carob Flour in the Treatment of Diarrhea in Infants and Children, *J. Pediatr.* 35:423 (Oct.) 1949.
Kaliski, S. R., and Mitchell, D. D.: Treatment of Diarrhea with Carob Flour, *Texas State J. Med.* 46:675 (Sept.) 1950.
Andrews, H. S.: The Use of Carob Flour in Gastro-Intestinal Disturbances, *J. Kentucky State M.A.* 49:279 (July) 1951.

Arobon, with its high efficacy in the management of diarrhea, meets the patient's demand for rapid relief.

Because of its high content of pectin, lignin and hemicellulose (22%), Arobon—made from specially processed carob flour—exerts powerful water-binding, toxin-adsorbing and demulcent influences within the bowel. As a result, subjective relief is quickly experienced, and stools begin to thicken and consolidate in a matter of hours.

In nonspecific diarrheas, Arobon serves well as the sole medication—in all age groups. In infectious dysenteries when specific chemotherapeutic or antibiotic agents may be required, it provides valuable adjuvant therapy, reducing the time required for recovery by as much as two-thirds.¹

1. Plowright, T. R.: The Use of Carob Flour (Arobon) in a Controlled Series of Infant Diarrhea, *J. Pediatr.* 39:16 (July) 1951.

Arobon is available in five ounce bottles through your local pharmacy.

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Arobon®

\$3; for daytime house calls, \$4. Then the climb begins. Fees for house calls at night rise from \$5 between 7 P.M. and 11 P.M. to exactly double that amount—\$10—between 11 P.M. and 8 A.M. Nor do these cover any medication or special procedures.

The schedule also includes some extras to discourage needless holiday calls and time-consuming visits to distant points. For example, a visit at 9 A.M. on Sunday to a patient living ten miles out of town would bring this bill:

Minimum for early-morning house calls	\$10
Additional fee for Sundays or holidays	1
Mileage for country calls, at 50¢ per mile one way ...	5
Total	\$16

Does this fee fence protect physicians from thoughtless demands on their time? Says Dr. D. W. Scott Jr., secretary of the local medical society: "Definitely, yes."

Court Supports M.D.'s On Fund Raising

Medical societies in two states have recently spoken out in behalf of independent status for all health and welfare agencies. And, for good measure, a court of law has chimed in.

The issue at stake: Whether these agencies should have the right to collect their own funds or be submerged in a united fund to conduct



Percy E. Hopkins
Wants free fund raising

a single solicitation. Resolutions reaffirming the agencies' right to operate independently have come from:

1. *Illinois*, where doctors urged that the National Foundation for Infantile Paralysis and other independent national health and welfare organizations "continue to possess complete freedom of action in raising the funds needed to carry on their works"; and

2. *Missouri*, where medical men feel that "the concentrated attack of [these] foundations upon dreaded diseases would be seriously threatened if they were required to become subordinated to a federated or joint fund."

Dr. Percy E. Hopkins of Illinois sums up the issue as follows: "If health and welfare agencies can be

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in
menopausal
therapy...



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through
lipotropic-estrogen
control

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The menopausal lipotropic, MENOTROPE corrects the interrelated lipid and estrogen imbalances of the menopause by providing a selected group of interrelated lipotropic agents essential to liver function and the utilization of estrogens.

The liver is important in both lipid and estrogen metabolism. Estrogen levels influence lipid metabolism and liver function. Therapy with MENOTROPE is therefore directed against a common physiologic denominator of the disorders often seen in menopausal patients.

Metabolic reorganization with MENOTROPE therefore, provides a fundamentally sound therapeutic basis for management of the menopause and its associated disorders.

indications

Menopausal symptoms unresponsive to routine therapy; diabetes or hepatogenic hyperglycemia at menopause; serum lipid disturbances (abnormal plasma lipid/cholesterol ratio) and fatty liver or atherosclerotic tendency associated with the menopause.

Menotrope tablets

menopausal lipotropic

formula: Each tablet of MENOTROPE contains Choline Bitartrate 80.00 mg.; Estrotate (estradiol-3-trimethylacetate) 0.33 mg.; Folic Acid 0.46 mg.; Vitamin B₁₂ U.S.P. 1.5 mc.

dosage: One to three tablets daily.

packaging: Bottles of 100 tablets.

regimented, why not medicine, education, and religion? . . . It is a short step from private bureaucracy to Government control."

Meanwhile, in Montgomery County, Ohio, a common pleas court has given substantial backing to the two medical society resolutions by upholding the right of the American Cancer Society to conduct an independent solicitation in the city of Dayton. The court ruled that a Dayton ordinance against any fund raising other than that of the city Community Chest drive was unconstitutional.

Is One Flight Too Much In an Emergency?

When a medical society maintains an emergency-call service, are individual doctors automatically relieved of all responsibility, even for emergencies that are close at hand?

This question came up recently in cliff-dwelling Manhattan, when the New York County medical society received complaints that doctors were refusing emergencies one or two floors away in their own apartment buildings. In one case, a patient died of a heart attack while neighbors sought in vain to get any one of several doctors in the building.

To avoid similar incidents and the adverse publicity that accompanies them, the New York society is now urging doctors to handle personally any emergencies in their apartment

houses. If a case calls for special care, the doctor is advised to stay with the patient and do his best until an ambulance or another physician arrives.

'Free-Care-for-Aged' Backers Woo Doctors

The long-expected drive to provide "free" hospitalization for about 7 million Social Security beneficiaries is on in earnest. No less than three identical bills advocating Federal Security Administrator Ewing's plan for the aged are now awaiting Congressional committee action. It will come as no surprise to doctors that among the bills' sponsors are two gentlemen named Murray and Dinglell.

Their proposed legislation, which follows to a letter the plan put forth by Mr. Ewing and endorsed by President Truman last year, would provide sixty days' free hospitalization a year for 5.5 million persons over 65 years of age and for 1.5 million wives, widows, and orphans who are covered by Federal Old-Age and Survivors Insurance. The cost of the program, put at about \$200 million for the first year, would be paid out of Social Security's surplus account.

When Ewing first discussed his plan last August, he made an effort to reconcile medicine's rank-and-file to the idea. The legislation's latest sponsors have, in turn, practically swamped the nation's doctors with

Edrisal: "an entirely adequate

substitute for ordinary doses of codeine..."

(Am. J. Obst. & Gynec. 61:1366, 1951)

but Edrisal contains no narcotics!

Each 'Edrisal' dose (2 tablets) contains:

'Benzedrine' Sulfate	5 mg.
(racemic amphetamine sulfate, S.K.F.)	
Acetylsalicylic acid	5 gr.
Phenacetin	5 gr.

please note: The color of the 'Edrisal' tablet is being changed from white to blue-green.

**Edrisal relieves pain and the depression
that magnifies pain**

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their solicitude. Originally, Ewing emphasized that eligible patients could enter a hospital only upon the recommendation of a physician, who would have complete control over the hospital admission.

To this, Messrs. Murray and Dingell add soothingly: "Doctors will be free to recommend hospitalization . . . without having to worry about whether or not the patient can afford to pay the hospital bill. The doctor will also stand a much better chance to collect his own bills promptly and in full once the hospital bill, biggest item in medical care costs, is out of the way."

Have You Ever Seen A Hospital Bill?

Inexperienced patients who expect their hospital bill to include only charges for room and board and nurse service are in for a rude awakening, says Dr. D. G. Miller Jr. of Morgantown, Ky. In fact, if the average M.D. were to see a breakdown of his patients' hospital bills, he too would be shocked. Reason: Many bills are padded with extras that are ridiculously overpriced, says the Kentucky physician.

A few examples of such extras that have come to Miller's attention:

¶ 10 to 25 cents for two aspirin tablets;

¶ \$10 for glucose, which costs about "\$2 per 1,000 cc.";

¶ \$20 for cast materials worth "less than \$5";

¶ \$45 for use of the cystoscopy room;

¶ \$15 to \$25 for local procaine anesthesia;

¶ \$10 for pathological examination of the "specimen removed at circumcision" of a newborn baby.

"At the rate that some of our hospitals charge now," says Miller, "patients [pay] as much for a soapsuds enema as . . . for an intravenous injection of the same amount." (An enema *ought* to be cheaper, thinks the Kentucky-G.P., since the patient "returns most of it . . . with interest.")

Miller's findings show that the guilty hospitals seem to bilk patients more on drugs than anything else. "One hospital," he says, "makes a profit of approximately \$100,000 a year from the drug room alone."

Not only must the hospital patient often pay for drugs he doesn't need; he must nearly always pay for more than he gets, says Miller. An example: "If penicillin is ordered, the patient is charged with a 10 cc. vial, regardless of whether he receives one or more doses. This penicillin remains on the ward and may be used to supply two or three doses to the next patient, who is also charged with a 10 cc. vial."

Even the hospital services of M.D.'s are not, he adds, always exempt from this kind of inflation. He has found particularly blatant examples of overcharges in hospital anesthesiology, pathology, and X-ray departments. "Too often," he reports,

X-ray procedures cost as much as they would if a "radiologist [had] done them in his own office and furnished all the materials plus the interpretation." Yet when the patient has paid for his hospital X-rays, he "is still required to pay for interpretation."


The problem of hospital overcharges is a very real one for every private practitioner, Miller warns. Reason: The patient is interested only in the total cost of his illness; and for the "high medical costs" on his hospital bill, he habitually blames his physician.

Dr. Miller gives an example from his own experience with a young girl who was injured in an automobile accident. "She had a right hemiparesis [plus] a contusion and con-

cussion," he reports, "and I feared a sub-arachnoid hemorrhage. She was hospitalized so that she might be immediately available to a neurosurgeon. She remained two days and nights in a ward for which the daily rate was \$7.50; yet her hospital bill was \$42.50, not including the X-rays." Miller admits he was at a loss for words when his patient asked him about the bill. "How can you explain such charges to a patient who received no services other than board and room while she was there?" he asks.

The average physician is not free of responsibility for hospital overcharges, he points out, since "many of us do not examine our patients' bills to see what they have been charged for." And there is one type

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XYLOCAINE®
(Pronounced Xí ló cain)
HYDROCHLORIDE
ASTRA
(Brand of lidocaine hydrochloride*)
AN AQUEOUS SOLUTION

a NEW local anesthetic

Dispensed in 50 cc and 20 cc multiple-dose vials containing 0.5%, 1% or 2% solution. All solutions available without epinephrine and with epinephrine 1:100,000. 2% solution also supplied with epinephrine 1:50,000.

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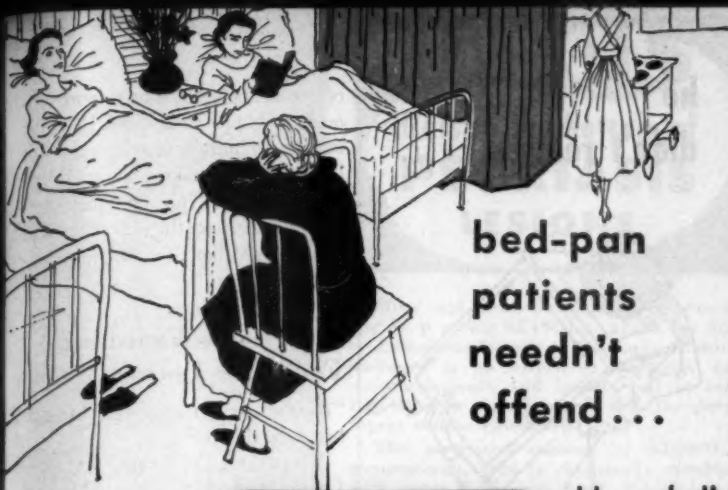


ASTRA PHARMACEUTICAL PRODUCTS, INC. WORCESTER, MASS. U.S.A.

(1) Hanson, I. R. and Hingson, R. A., *Current Researches in Anesthesia and Analgesia*, 29:134 (May-June) 1958.

*U.S. Patent No. 2,441,499

292



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patients
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Well known for its unique ability to deodorize foul-smelling lesions when applied *topically*, CHLORESIUM Chlorophyll provides an effective solution to a particularly distressing odor problem when administered *orally*. In a recent study¹ on colostomy patients, it was found that "within forty-eight hours there was a striking reduction in objectionable odor, to the gratification of not only the patients themselves but also of staff members and other patients in the ward and adjoining beds."

Initial dosage of two tablets four times daily, then one tablet four times daily, is usually sufficient to control bed-pan or colostomy odors.

in mouth, breath and body odors, CHLORESIUM's concentrated highly purified water-soluble chlorophyll provides simple, economical, yet effective deodorization. Prescribe CHLORESIUM TABLETS whenever odor control is indicated. Average dose one tablet daily.

supplied: boxes of 30 tablets, bottles of 100 and 1,000.

1. Weingarten, M., and Payson, B.: Deodorization of Colostomies with Chlorophyll, *Rev. Gastro-Enterol.* 18:602, 1951.

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**he
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**that unusual strain ...
caused muscle pain**

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**will give relief from
joint and
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of doctor, he adds, who is more seriously to blame than most. He is the man "who literally practice[s] out of [his] bag." By making use of the hospital for all his "physical facilities," he helps increase the cost of medical care, says Miller, "by adding to hospital overhead."

Color Lines Vanishing For Negro Doctors

"The barriers of segregation are breaking down."

Thus does Dr. Franklin C. McLean, secretary of National Medical Fellowships, Inc., summarize the outlook for Negroes in medicine. In basing his optimism on an authoritative report covering the past six years, he reveals that:

¶ There were 143 Negro medical students in forty-three "white" schools in 1949-50—an increase of 318 per cent in ten years;

¶ There are 190 Negro certified medical specialists today, as against ninety-three in 1947;

¶ There are sixty Negro Fellows of the American College of Surgeons today, as against none five years ago.

"Negroes," says McLean, "may be found in increasing numbers on the staffs of hospitals, as students in unsegregated medical schools, and on their faculties. Of special significance is the change in several Southern universities . . . More and more non-Negro hospitals and teaching centers are accepting Negroes as internes, residents, and staff physicians and surgeons." A recent survey in Chicago, he reports, shows that

RIASOL

Gets to the bottom of PSORIASIS LESIONS

More and more physicians are prescribing deep acting RIASOL to reach the deeper cutaneous lesions of psoriasis. Although mercury is an effective alternative, ordinary ointments and lotions fail to bring this drug in actual contact with the deeper layers of the epidermis.

The mercurial content of RIASOL is saponaceous, that is chemically combined with soaps. Like soap itself, it is detergent and penetrates the horny layers of the stratum corneum. This keratolytic action, combined with the alternative effect of saponaceous mercury, accounts in part for the remarkable therapeutic results obtained with RIASOL.

Actual clinical tests proved that RIASOL cleared up or greatly improved the skin lesions of psoriasis in 76% of all cases treated in a controlled clinical group.

RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

Ethically promoted RIASOL is supplied in 4 and 8 fl. oz. bottles, at pharmacies or direct.

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Please send me professional literature and generous clinical package of RIASOL.

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Before Use of Riasol

After Use of Riasol

From where I sit by Joe Marsh



**Whitey Sure
"Rang the Bell"**

Telephone woke me out of a sound sleep last Friday about eleven-thirty. "This is Whitey Fisher out on River Road," says a voice. "I just wanted to tell you how much I like this week's *Clarion*."

"Thanks, Whitey," I told him. "But why in blazes call to tell me at this time of night?" "Simple," he says, "your paper boy just delivered it a short while ago. Been waiting for it all evening."

Next day, Buzzy Wilson tells me he delivered Whitey's paper late because he stayed for the school dance and thought it would be OK to drop it off on his way home.

From where I sit, I can't blame Whitey for his joke. He was just reminding me we owe other people the same respect we expect from them. Since I'm always talking about the other fellow's rights—like his right to enjoy a glass of beer and his right to practice his profession without interference, it was only fair that Whitey should "wake me up" to his right to get his copy of the *Clarion* on time.

Joe Marsh

Copyright, 1952, United States Brewers Foundation

between thirty and forty Negroes are serving on the medical staffs of eleven non-Negro hospitals.

Although the trend is encouraging, Dr. McLean points out that Negroes are a long way from having proportional representation. "If Negro students were enrolled in medicine in proportion to their number in the population, there would be approximately 2,600 in training instead of the 700 at present," he says.

In its efforts to increase the Negro's stake in medicine, National Medical Fellowships has made a record number of awards for 1952-53, to help colored students in medical schools and pre-medical courses. Additional awards provide for the training of Negro specialists in dermatology, internal medicine, obstetrics and gynecology, ophthalmology, orthopedics, pediatrics, psychiatry, radiology, and surgery.

Supermarkets Click With Drug Sales

Drug products are among the most popular and profitable items in large food markets, according to the trade journal *Progressive Grocer*. The magazine reports that more than 65 per cent of the leading food stores now carry headache remedies, first-aid supplies, laxatives, cold remedies, and a host of other products formerly found only in drugstores.

And the consumer public loves it, as witness the \$340 million worth of drugstore items sold by food markets in 1951. The sale of drug items, which get a high 30 per cent mark-

~~safetu~~

IN THE PROLONGED CONTROL OF HYPERTENSION

No other hypotensive product combines such high efficacy with so much safety as Veratrite in the treatment of mild or moderate hypertension.

The fall in blood pressure is gradual and prolonged. Subjectively, the patient's well-being is restored by relieving headache, dizziness and easy fatigue.

CASE 36
Benign Essential Hypertension

History of headaches and transient ankle edema for 5 years. B.P. 180/110 on first examination; no other pathology. Veratrite therapy prescribed, 1 tabule t.i.d., continued for 1 year. Considerable improvement of subjective symptoms. Fall in B.P. to an average of 136/80. Complete absence of toxicity.

Each tabule contains:
Whole-powdered Veratrum Viride 40 C.S.R.* Units
Sodium Nitrite 1 grain
Phenobarbital 1/4 grain

*Irwin-Neisler whole-powdered Veratrum viride specialties are now assayed by the Carotid Sinus Reflex method (40 C.S.R. Units approximately equivalent to 3 Crawford Units).

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IN MILD AND MODERATE HYPERTENSION

Whole-powdered Veratrum viride (Irwin-Neisler) supplies all of the alkaloids and glycosides of the drug to produce a longer duration of action within a wide margin of therapeutic safety.

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Quick Relief for Patients With



You Can Prescribe Dr. Scholl's Arch Supports With Confidence

The patient will be properly fitted and the Supports periodically adjusted as condition improves, at no extra cost. This Service is available at many Shoe and Department Stores and at all Dr. Scholl's Foot Comfort® Shops in principal cities.

Dr. Scholl's ARCH SUPPORTS

up, represents about 2 per cent of the total sales in the big markets, the grocers' journal reports. This is said to be an enormous sales volume for one class of product in the food field. And the future, says the Progressive Grocer, looks even more bullish.

How do druggists feel about this turn of events? According to the journal, they were alarmed at first, but they've found that the food stores are not too great a threat, since the food people find it profitable to handle only the two or three hundred fastest sellers. That leaves nearly 50,000 items (and more than 95 per cent of total sales) for the drugstores.

Neglected Executives Now Offered Medical Aid

Strange as it may seem, the American executive is among the "medically underprivileged." This, at least, is the opinion of New York's Madison Foundation for Biochemical Research, which has set up a preventive medical service for business men.

Medically speaking, explains Samuel Markel, chairman of the foundation, the average business executive is not as well off as the average industrial worker. So the executive "dies nearly six years sooner than his employe." This, says Markel, "represents a staggering annual loss to American business."

The diagnostic unit that will give yearly checkups to executives is the Fanny Markel Medical Group, an

it's the *healing* influence
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affiliate of the Madison Foundation. It has a staff of fourteen physicians in all fields of medicine, as well as complete laboratory and medical facilities. A checkup will cost \$75, regardless of the number of services required. The diagnostic service, which has been approved by the New York County medical society, is being offered to business firms on a group basis.

The function of the medical group, however, will be purely diagnostic. Executives who need treatment will be referred to their own physicians.

Medical Students Become Family Health Advisers

Some eighty students at the University of Pennsylvania School of Medicine are now getting what amounts to on-the-job training in family medicine by acting as "family health advisers." Each student who elects this course is assigned to a particular family during his first year in medical school and, if possible, continues with this family till graduation.

By spending about six hours a month with the family, the student gets to see its members not only in the hospital and clinic but—just as important—in the home. And he gets to know its economic and psychological as well as its health problems. The value of the program, say its sponsors, is that the student becomes familiar with family problems *gradually*, rather than having them thrust upon him all at once when he enters private practice.

Such families (drawn from the



A safe, **two-fold lift** for the convalescent, the aged, and the patient with psychic fatigue—in **palatable Elixir Gerone**.

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middle- to low-income groups) understand that they cannot expect treatment from their adviser, since he is a "doctor in training" (this term is thought preferable to "medical student"). If a family has a regular physician, his approval and co-operation are sought before the student is assigned.

How do the students like the idea? When the course was first offered to the university's entering class in 1949, more than half the 125 class members applied for it—even though it was pointed out that the student would have to spend a great deal of his free time visiting the family. At first, only fifteen of the highest ranking students could be accepted, but last year the course was enlarged to accommodate forty new first-year health advisers.

Evidence of student endorsement may be found in the comments of some of the family health advisers themselves. Said one after his first year with a family:

"I feel that this experience has given me some needed confidence in . . . establishing a professional relationship with people."

Said a second-year man:

"In the hospital . . . many of the doctors . . . take an impersonal viewpoint of their patients and treat them as some inanimate object . . . The doctor will . . . completely ignore the patient, not tell him what his trouble is or endeavor to allay his fears. Therefore, many patients work up strong apprehensions. The student, being taught in [such an] environment, naturally is molded to it by



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the time [he enters practice]. He then doesn't know how to handle a patient, especially in a country community where he is not working in a hospital. This situation can be remedied to a great extent by the type of experience . . . we are now having."

The program has its critics, of course. Some, for instance, think that the students are assuming too much responsibility too soon. But sponsors of the course report that the student advisers have shown "a very keen sense of their own limitations." Every doctor, they add, must sooner or later learn to say "I don't know" without undermining his patient's confidence.

At Pennsylvania, the consensus seems to be that the sooner a student learns this, the better.

**When They Ask You,
 'What's New?'**

If you've been a frequent guest speaker at medical meetings, you've probably been bombarded by newspaper reporters with the question, "What's new?" Sometimes it's a hard one to answer in a few simple words. But for physician-speakers in Colorado these days, the question no longer brings on a fit of stammering; for they have the answer ready.

Stealing a march on the reporters, Colorado's medical society now asks guest speakers to consider the ubiquitous question *before* newshawks get around to it. Some weeks in advance of a meeting, each speaker receives a form on which he is asked to summarize his paper in "lay language."

...the best is yet to be



For those approaching middle life, the years ahead can be the best — provided normal metabolic functions are safeguarded. In such interrelated disorders as atherosclerosis, diabetes mellitus, and liver disease, the clinical findings are likely to include abnormal fat metabolism (with accompanying deposition of cholesterol) and abnormal capillary fragility.

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guage" and to list "anything new." The form is then returned to the planning committee, so that a press release can be prepared. If a reporter wants to know more about the subject, a follow-up interview is arranged. Chances then are that both the reporter and the physician will be better prepared.

Physicians See Movie of Health Plan Office

Many physicians may think that their Blue Shield offices do nothing more than write checks. Happily, they do write checks, but they do a great deal more—as hundreds of California physicians are learning these days.

Members of that state's medical society are currently getting a bird's-eye view (or, more precisely, a camera's-eye view) of their health plan, the California Physicians' Service, at work. Through the medium of a new motion picture, doctors in fifty-eight California counties are being taken into the plan's offices to see how it processes and pays some 65,000 claims a month.

A good part of the forty-minute film is devoted to showing what happens to a doctor's claim once it clears the C.P.S. mail room. The claim is traced, step by step, through the identification, medical, and accounting departments to the payment section.

A portion of the film is devoted, as well, to the history of an imaginary but typical C.P.S. subscriber. This gives the C.P.S. people a

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chance to pass along some helpful hints on doctor-patient relations. One of the problems the motion picture takes up, for example, is how to discuss balance charges with patients who are over the plan's income ceiling. Here, in an excerpt from the dialogue of the film, is how this problem in doctor-patient relations might ideally be solved:

PATIENT: Doctor, your receptionist said I should talk to you about your fee because I am over the income ceiling.

DOCTOR: Yes, I see you've indicated [on the C.P.S. form] that your income is more than \$4,200.

PATIENT: Yes. My husband and I both work. Neither of us makes more than \$4,200 separately, but together we do.

DOCTOR: About how much do you estimate your combined income is?

PATIENT: Well, I earn \$200 a month and my husband makes \$300.

DOCTOR: That's \$500 per month, or about \$6,000 a year. (Pause.) I'll probably submit a bill to you for part of my fee. You understand that C.P.S. fees are not full payment for persons over the \$4,200 ceiling?

PATIENT: Yes, I understand that. Can you tell me how much you will charge me?

DOCTOR: I can't say exactly for this operation until I've completed the surgery. The operation may be minor or radical. We hope it will be minor. Depending on the surgery, my bill to you, in addition to what I receive from C.P.S., may be from \$25 to about \$100.

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Memo from the Publisher

● Medicine's problems can seldom be solved behind closed doors. But they are often solved by frank and open discussion.

The pages of MEDICAL ECONOMICS reflect this belief—and by design. For we have long considered frank talk our chief stock in trade.

Yet to certain people at certain times, frank talk is inevitably embarrassing. Almost every month we're asked not to publish particular facts, opinions, or even whole articles.

Sometimes we're subjected to a good deal of pressure from those who "don't want anything said," or who "can't see why you want to stir things up," or who'd "like to protect the doctor from publicity."

Resisting such pressure is one of our hardest jobs—but resist we must. For our primary aim is to help our 134,000 physician-readers. And doing this means putting their collective interests above those of any individual.

A case in point was our recent report on Dr. Hermann Sander and his experience since being acquitted

of an alleged mercy killing. Plenty of people urged us to drop this project, among them the officers of the state and county medical societies and Dr. Sander himself. Yet we became convinced that the professional issues involved were of legitimate interest to doctors everywhere. So we went ahead with the story.

We went ahead, too, with our May article on Dr. Andrew C. Ivy, despite vigorous objections from some of his friends. His sponsorship of the secret drug Krebiozen raised issues that, in our opinion, were important to all doctors—and hence worth reporting candidly.

We have to override similar objections almost every time we probe one of medicine's trouble spots—for example, fee splitting. We don't like being obliged to offend people now and then (sometimes they're good friends). But only if we print facts as we see them can we fulfill the true purpose of an independent professional magazine.

Such a magazine, it's often said, can stimulate a good deal more constructive action than either viewers-with-alarm outside the profession or viewers-with-equanimity inside the ranks.

But constructive action is possible only when the truth is not varnished, when words are not minced, and when every side is given its say.

—LANSING CHAPMAN

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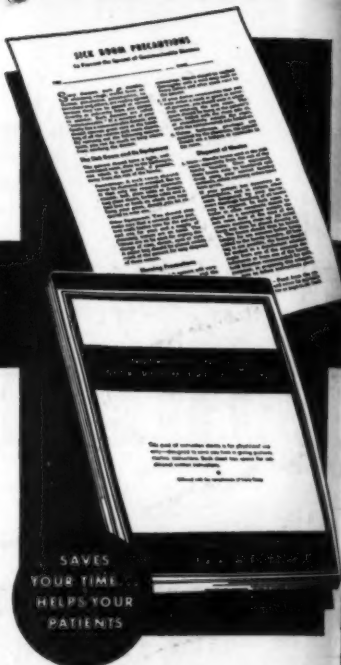
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- No. 6: "Sick Room Precautions."